Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamek, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

15 MAY 1984

VOLUME 146

OFFICIAL COURT REPORTERS

Angus, Stonehouse & Co. Ltd.,
14 Carlton Street, 7th Floor,
Toronto, Ontario M5B 1J2

595-1065

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND RELATED MATTERS.

Hearing held on the 8th Floor, 180 Dundas Street West, Toronto, Ontario, on Tuesday, the 15th day of May, 1984.

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THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner

THOMAS MILLAR - Administrator

MURRAY R. ELLIOT - Registrar

APPEARANCES:

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I.J. ROLAND M. THOMSON R. BATTY	Counsel for The Hospital for Sick Children
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K. CHOWN	Counsel for numerous Doctors at The Hospital for Sick Children
B. SYMES F. KITELY	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

(Cont'd) .....

APPEARANCES (Continued)

D. BROWN	Counsel for Susan Nelles - Nurse
P. RAE	Counsel for Phyllis Trayner Nurse
J.A. OLAH	Counsel for Janet Brownless R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)

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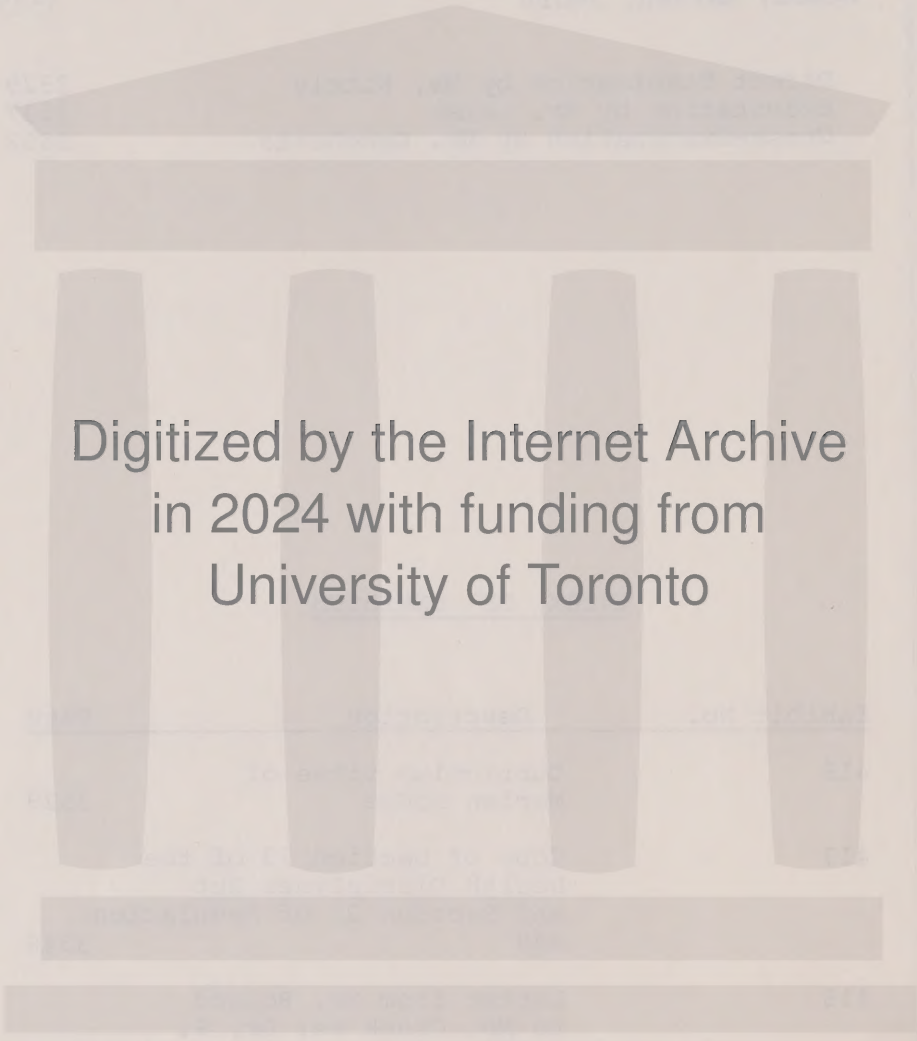

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---(Upon commencing at 10:00 a.m.)

THE COMMISSIONER: Who is taking the witness?

MS. KITELY: Good morning, sir.

THE COMMISSIONER: Yes, Miss Kitely.

MS. KITELY: Mr. Commissioner, sitting at your right is Dr. Marian McGee. I will ask the Registrar to swear her.

MARIAN McGEE, Sworn

MS. KITELY: I have given to the Registrar copies of the curriculum vitae Mr. Commissioner. I plan to highlight some of the contents of it.

THE COMMISSIONER: Yes, all right. 416.

--- EXHIBIT NO: 416: Curriculum vitae of Marian McGee.

DIRECT EXAMINATION BY MISS KITELY:

Q. Dr. McGee we have a curriculum vitae. I believe you have a copy?

THE COMMISSIONER: Miss Kitely, before we start, there were all sorts of complaints in the media about hearing problems. I wonder if we could just see. Can you hear at the back?

MS. KITELY: I was turning sideways in

the hope that that would be improved, sir.

THE COMMISSIONER: Dr. McGee seems to have two microphones and so do I. That seems unfair. Does anybody know why we have two microphones each?

MR. MacLEOD: One is going to the monitor and the other for here.

THE COMMISSIONER: We have two.

MR. MacLEOD: One for the overflow room and the other two for here.

THE COMMISSIONER: There is none available for council then?

MR. MacLEOD: The one on the wall is for the overflow room but not picking up for here.

MS. KITELY: I will try to shout, sir.

THE COMMISSIONER: Yes, all right. Thank you.

Q. Miss McGee, looking at your curriculum vitae I understand that you are presently Associated Dean of the Facility of Health Sciences in Ottawa?

A. University of Ottawa, that's correct.

Q. You have been in that position

since July 1981?

A. That is correct.

Q. And that comes with the dual position, as Professor and Director of the School of Nursing at the University of Ottawa?

A. Correct.

Q. You have held that position likewise since July, 1981?

A. Right.

Q. Can you help us with how your function, as a Director of a Nursing School relates to the practice of nursing in a Hospital?

A. As Director of the School of Nursing one is attempting to facilitate the production of graduates of nursing baccalaureate graduates, more precisely, that for the most part are going to be employed by Hospitals across the country and, therefore, their practice confidents, their knowledge level and their science base is of interest, needless to say, to the health care system.

Q. Am I correct that the University of Ottawa, School of Nursing, has certain affiliated hospitals?

A. Yes.

Q. And would I be correct

that those are primarily the Ottawa General Hospital, the Ottawa Civic Hospital, the Royal Ottawa, which is a psychiatric hospital and the Children's Hospital of Eastern Ontario?

A. That's correct.

Q. Last being obviously --

A. A children's hopsital.

Q. Is it fair to say, then, if those Hospitals are affiliated with your School of Nursing that you must have a familiarity with all of the gamut of health care in the Hospital?

A. That is correct.

Q. Am I correct that within your functions as Director of the School of Nursing that you meet approximately once a month with nursing executives of the various Hospitals with which there is an affiliation?

A. Yes, actually it would be at least once a month. Sometimes it is more frequently.

Q. The purpose of such meetings would be on the one hand to ensure that your teaching needs are being met and on the other hand the service needs for the Hospital are being met vis-a-vis your students?

A. Yes, sir, vis-a-vis the

students in that I want to make sure the content and relationship with the Hospitals is appropriate.

Q. Now, I understand, Dr. McGee, that prior to being at the University of Ottawa that you were at the University of Western Ontario?

A. That's correct.

Q. And you performed in that capacity as an Associate Professor for approximately six years?

A. Correct.

Q. Prior to that I understand from looking at your curriculum vitae that you were in Baltimore, Maryland for the better part of the years 1957 to 1975?

A. That is correct.

Q. And that during the years you were there that you functioned in various capacities, both in academia and in staff nursing positions?

A. Correct.

Q. Before leaving for the United States, and at the top of page two of the curriculum vitae I understand from periods of 1955 to 1957 you had worked as a Public Health Nurse in Ontario?

A. That's correct.

Q. And that prior to that you worked as a Staff Nurse at Kitchener/Waterloo Hospital?

A. That's correct.

Q. Am I correct that when you did work at the Kitchener/Waterloo Hospital it was in the area of paediatrics?

A. Yes.

Q. Now, looking at page two of the curriculum vitae and specifically the category of education, I gather that you received your diploma in nursing in 1953?

A. Right.

Q. Followed by a Bachelor of Nursing Science in 1966?

A. Correct.

Q. A Masters of Public Health in 1970?

A. Right.

Q. And finally your Doctorate in 1980?

A. Correct.

Q. Looking at the category of research activities there is the obvious first one,

namely, your dissertation for your doctorate; is that correct?

A. Right.

Q. Moving down then to the items described under 1966 to 1970, I see there is a particular research study, in which you developed epidemiological investigation of poison ingestion in pre-school children in the Baltimore, Maryland; is that correct?

A. That is correct.

Q. Am I correct that study over a two year period encompassed some 5,000 subjects?

A. That's right.

Q. The next item under that period of years indicates that while you were performing in two functions, namely supervisor of the Baltimore City Health Department and Senior Co-ordinator at the Community Nursing in the John's Hopkins School of Nursing, there was a study with respect to medication errors conducted?

A. Right.

Q. Before we get to the study, if we can back up a bit I understand that those capacities required you to supervise roughly 100 students?

A. Over the course of the year

there were 100.

Q. And the function of those students were to care for post- hospitalization, ambulatory patients?

A. Of a particular hospital, yes.

Q. These were patients then who had been in Hospital, who had been discharged, or under care at home?

A. That's correct.

Q. The function of your students was to actually visit the patient in the Hospital?

A. That's correct.

Q. And we call this a morbidity care program?

A. That is what we call it.

Q. I gather that during the course of these students working with the patients at home that they had to deal with the medications that the patients were prescribed before they left the Hospital?

A. And after. They were to monitor the patients taking their medications.

Q. And am I correct that some of these patients would have been given a prescription in the Hospital?

A. Right.

Q. That would have been filled in the Hospital Pharmacy or in a Community Pharmacy?

A. That's correct.

Q. It came to your attention through your students that there were, in fact, errors occurring in certain medications; is that correct?

A. Yes.

Q. And was it because of this information coming to your attention that the survey was undertaken?

A. That's correct.

Q. And is it fair to say that the objective of the survey was to identify the errors own their sources?

A. That is correct.

Q. Am I also correct that you used the patients who were being cared for by the students as a sample?

A. That's all.

Q. It was a narrative survey as opposed to an epidemiological survey?

A. That, too, is correct.

Q. I understand the students were then required to do certain functions in the

midst of the study and one was to collect data from the Hospital, if that is where the medication was prescribed, as to what medication was prescribed?

A. Yes, confirm the original order.

Q. And they would do that by looking at the chart?

A. That's correct.

Q. Would they also check the dose?

A. Check the dose, the type and the times.

Q. Would they then, having checked that information in the chart, compare it with the medication in the possession of the patient?

A. That's correct.

Q. If there was discrepancy did they then analysis where the discrepancy occurred?

A. Yes, they would confirm the original order and confirm that the medication the patient had was, in fact, the order given including the regimen that it was to be given under.

Q. If there was a discrepancy then that is exactly what the study was aimed at

finding out. how the discrepancy --

A. That is right, to identify the discrepancy, identify the error.

Q. Am I correct that these nurses that, or student nurses that were in the program did not actually administer any medication?

A. No. Their mission was to monitor the medication and they wanted to supervise patients to make sure they were taking the medication correctly. That was the mission.

Q. But if the individuals were not actually administering it then presumably they could not be a source of error?

A. That's correct.

Q. In this particular study?

A. In this particular study.

Q. Am I correct that the conclusions generally described in this study indicated the errors occurred in three places, position order being one?

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A. Physician order being one. That is the order that was originally on the chart, but the order, the prescription order to the pharmacist, the pharmacist filling the order, and then of course the patient taking the medication.

Q. Now I gathered from looking at your curriculum vitae again at the top of page 3 that the results of this study are unpublished?

A. That's correct.

Q. Now if I can go to page 3 of your c.v. and I note under the heading of the consultantships that the first one is that you are presently a consultant to the College of Nurses of Ontario, and that's in a specific role to review the standards of nursing practice. Is that correct?

A. Revise the standards.

Q. Revise the standards. And am I correct that the standards apply across Ontario?

A. That's correct.

Q. And that the report that the task force is going to prepare is going to coincide with the revision of the Health Disciplines Act and Regulations currently undertaken by the Ministry of Health?

A. It is a concurrent process.

Q. And is it fair to say that the

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report of the task force of which you are a member will probably havean impact on the standards by which nurses practice throughout the Province?

A. I would anticipate that there would be some.

Q. Now still dealing under the heading of consultantships I want to point to one other one, and I see the third one down indicates that you are presently on a resourse committee of the Children's Hospital of Eastern Ontario, and in that connection you conduct workshops approximately once every two weeks with a particular group of nurses at that Hospital. Is that correct?

A. That's correct.

Q. And that is an on-going process?

A. It has been on-going.

Q. And I gather in looking generally at your c.v. there have been a variety of other consultantships over the last number of years, both since you have been associated at the University of Ottawa and the University of Western Ontario?

A. Yes, that's correct.

Q. And just highlighting the topic of workshops I gather that you have given a variety of workshops, one or two days as the case may

be, to a variety of nursing personnel across the Province?

A. Yes.

Q. And finally looking at the category of other professional activities it would appear that you are involved in two areas; one in a hospital level and on the other hand national and provincial eductional committees. Is that fair?

A. That is fair.

Q. And if we leave off with the last category, I gather that you have prepared papers or given addresses on a variety of occasions on a variety of topics relating to the delivery of health care?

A. Yes.

MS. KITELY: Mr. Commissioner, I gather that the curriculum vitae has been marked Exhibit 416?

THE COMMISSIONER: Yes, 416.

MS. KITELY: By way of summary, Dr. McGee, is it fair to say that the results of your 31 years associated with delivery of health care, both in Ontario and outside of Ontario that you have practical experience with respect to staff in the Hospital?

A. Yes, I think so.

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Q. And you have personally worked independently of hospitals?

A. Outside of hospitals, yes; in public health care.

Q. Is it fair to say you have knowledge about various areas of nursing including administration, occupational health, public health nurses, staff nurses and academia?

A. I have had experience in those areas.

Q. And that has required you to have a fairly significant interaction with other health care disciplines?

A. Oh, yes.

Q. And would that also put you in a position of having an understanding of the requirements of the standards of nursing practice in Ontario?

A. Yes.

Q. Now in preparation for your attendance here today am I correct that you have read a variety of Exhibits and material,

and by way of example am I correct you have read three articles with respect to medication error. Those we have identified as Exhibits 222, 223 and 248,

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and I think you looked at the numbers before the hearing started today?

A. Yes. I remember looking at them. I am not sure what the numbers were.

Q. Am I correct that you reviewed the communication books and ward meeting books which are marked Exhibits 300 and 301?

A. I -

Q. To the extent that you could read them?

A. I did scan them, yes. I went over them.

Q. Am I correct that you read an excerpt from the testimony of Carol Brown with respect to the relationship between the standards of nursing practice and the Hospital Manual of Procedures?

A. Yes, I did.

Q. You have looked at parts of the chart of Baby Miller which has been marked Exhibit 115?

A. Yes.

Q. That you have reviewed a portion of the cross-examination by Ms. Cronk, Commission Counsel, of Gloria Bucci?

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A. Yes.

Q. That you have reviewed various hospital documents including patient care plan which is Exhibit 307?

A. Yes.

Q. And the fluid record work sheets which is Exhibit 154?

A. Yes.

Q. That you have reviewed Exhibit 342 being a description of a team leader?

A. Right.

Q. And that you have reviewed Exhibit 304 being a diagram of wards 4A/4B during the period in question?

A. Yes.

Q. You have looked at in some respects the Manual of Nursing Practice which is Exhibit 291?

A. Yes. I didn't look at all of it, but I looked at some of it.

Q. That is not meant to be an exhaustive list but is that the highlight of the things that you have looked at in order to prepare for your attendance today?

A. Yes.

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Q. Am I correct that you attended here briefly yesterday and saw a short portion of the evidence of Dr. Kantak?

A. That's correct.

Q. And am I also correct the Hospital was kind enough to arrange for your attendance at the Hospital to view wards 4A and 4B?

A. Yes.

MS. KITELY: Mr. Commissioner, before I go on to the next step may I just indicate to you where I am going with this witness?

THE COMMISSIONER: Yes.

MS. KITELY: I have four areas I wish to cover. First of all a very brief what I call a housekeeping matter. During the evidence of Carol Brown there was some discussion about relationships between the standards and the manual and I wish in about two and a half minutes to clear that problem up as I undertook to you to do.

THE COMMISSIONER: Yes.

MS. KITELY: Secondly I wish to deal with the general area of medication error. Thirdly I wish to deal with the general area of charting, and fourthly I intend to deal with various hypothetical fact situations of which I will seek the Doctor's

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opinion.

THE COMMISSIONER: Yes. All right.

MS. KITELY: Q. Dealing with the housekeeping matter, Dr. McGee -

THE COMMISSIONER: Hopefully in this hypothetical fact situation you will tell the rest of us what they are based on because I assume they are based upon factual situations in the first place.

MS. KITELY: That is correct. They are based on portions of the transcript.

THE COMMISSIONER: Yes. All right.

MS. KITELY: Dr. McGee, we have marked as an Exhibit No. 292, the Standards of Nursing Practice in Ontario, and I gather from your evidence that you are familiar with that document?

A. Yes, I am.

Q. Am I correct that it is in fact the Health Disciplines Act that governs the practice of nursing in Ontario?

A. That gives the mandate to the College of Nurses, yes.

Q. And pursuant to Section 73, of the Health Disciplines Act, sub-paragraph (f) provides that the Lieutenant Governor in Council may make regulations governing these standards of practice for

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the profession, and are you familiar with regulation 449 which in fact sets out some of the standards?

A. Yes.

Q. And specifically in regulation 449, section 21 provides that for the purposes of part 4 of the Act, professional misconduct means, sub-paragraph (a) the contravention of any provision of part 4 of the Act or the Regulation?

A. Yes.

MS. KITELY: Mr. Commissioner, I would offer, if I could get through the chairs, a copy of Section 73 of the Health Disciplines Act and Section 21 of Regulation 449.

THE COMMISSIONER: Yes. All right. I guess it is a public document. Do you want it as an Exhibit? You don't need it as an Exhibit.

MS. KITELY: I am in your hands, sir.

THE COMMISSIONER: Exhibit 417.

---EXHIBIT 417: Copy of Section 73 of the Health Disciplines Act and Section 21 of Regulation 449.

MS. KITELY: Now aside from the standards which the regulations provide for, am I correct that in most hospitals the procedure is set up for the responsibilities of various of their personnel?

A. Yes, usually.

Q. And by way of example at the Hospital for Sick Children there was a document which is Exhibit 291 being the manual, the Hospital Manual?

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A. Yes.

Q. Now I am going to put to you a scenario, and I will ask you to agree to disagree with me on this.

If the Standards of Nursing Practice Exhibit 292 provides that a registered nurse or a registered nursing assistant is empowered to do X, function X, and if the Hospital Manual provides that that same individual can perform function X plus 1?

A. Yes.

- - - -

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C-1

Q. What is the position of the RN or RNA?

A. In terms of the X plus 1 she is subject to the discipline of the College, in other words she does it on her own.

THE COMMISSIONER: What about the Hospital, what happens?

THE WITNESS: Well in relation to the College and since the College has the mandate for the supervision.

THE COMMISSIONER: It puts the nurse in a terrible position though, doesn't it? If she is told by the Hospital she is entitled to do X plus 1 and the Health Disciplines Act says she can only do X, she is in what we sometimes call a dilemma.

THE WITNESS: Yes, just a bit, sir.

THE COMMISSIONER: And one truly can't solve it.

THE WITNESS: Well it is not easily solved.

THE COMMISSIONER: However, your position is the Regulation governs.

THE WITNESS: That is correct, sir.

MS. KITELY: Q. Now let me put the

converse of that to you, if the Standard of Nursing Practice provides that an RN or an RNA is empowered to do function X and the Hospital Manuel provides that the same individual can do X minus 1, what is the position of the RN or the RNA?

A. The probability is that she will conform to the Hospital but under the mandate of the College she can't perform to X, it also presents a local dilemma.

THE COMMISSIONER: She will still be a good nurse but she will be fired by the Hospital.

THE WITNESS: There is a risk.

MS. KITELY: Mr. Commissioner, that is all I planned to do with that, I was not going to open up the detail that we dealt with through Nurse --

THE COMMISSIONER: I would just like to ask if any nurse has been prosecuted for doing what the Hospital tells her to do and it is contrary to the Regulations; do you know of any instances?

THE WITNESS: I know of instances, sir, I can't state them, but I know they exist.

MS. KITELY: It has happened, sir.

THE COMMISSIONER: I would like to report it to the Civil Rights Assocation ---

MR. ROLAND: Sir, I understand it has happened. It has not as far as we know and as far as my friends know it has not happened with respect to the Hospital for Sick Children. I don't want anybody to misunderstand that this is happening at the Hospital for Sick Children. There has not been any evidence of that and as I understand it they have not experienced that.

THE COMMISSIONER: The Hospital for Sick Children is sterner with their regulations, I think that is the evidence that we did have.

MR. ROLAND: That would not put the nurse in any jeopardy with the College.

THE WITNESS: That is correct.

THE COMMISSIONER: No, it wouldn't.

MS. KITELY: Mr. Commissioner, I intended to move on to the next general area that being the topic of medication error.

THE COMMISSIONER: Yes. All right.

MS. KITELY: Q. Dr. McGee, we have heard a variety of evidence in the course of our 140 odd days of hearing that medication error might have contributed to the death of some of the children for which the Commissioner is concerned and I wish to

highlight some of that evidence to you.

First of all, if I can look at the Dubin Report; have you read the Dubin Report independently of these hearings?

A. I have read parts of it, I haven't read the total document.

Q. Now looking at chapter 15, page 194, and I am going to suggest three different sets of numbers to you Dr. McGee and then ask you a question. Looking at page 194 on the lefthand side at the bottom, there is a reference to a study by authors Davis and Cohen in which they found average error made of 11.6 per cent.

A. Yes.

Q. I am next going to refer you to evidence by Dr. Spielberg, who is a Pharmacologist at the Hospital for Sick Children who, at volume 56 and at page 2381 was asked about error rates and he looked at Exhibit 222 which was one of the medication error rate studies which you indicated you had looked at.

THE COMMISSIONER: 222 is it?

MS. KITELY: 222, yes. Mr. Registrar, could the witness have Exhibit 222.

Q. If you look at page 10 of Exhibit 222, specifically at the lefthand side in the middle, Dr. Spielberg in his evidence at volume 56 referred to and I am quoting:

" 93 errors were noted resulting in an error rate of 18.4 per cent and if wrong time errors were eliminated the error rate would be 16.6 per cent. "

Dr. Spielberg in his evidence at page 2381 suggested that the error rate, overall error rate in a non-unit dose hospital might vary from 5.3 per cent to a bit greater than 20 per cent.

Now the last reference that I wish to make is to Dr. MacLeod, who is likewise a Pharmacologist at the Hospital for Sick Children and he referred to Exhibit No. 255. Mr. Registrar, could the witness have Exhibit No. 255 please.

I will ask you to look at the - the pages are not well-numbered, but would you look at table five which is about the third page in.

A. Yes.

Q. And in the middle of that table, error rate, excluding wrong time, vary from 3.7 in Hospital B to 14.6 in Hospital - I am sorry

Mr. Commissioner, I have the wrong number; 8.9 in Hospital A to 14.5 in Hospital B.

A. Right.

Q. And Dr. MacLeod putting the material as a reference point at page 4308 -

MR. LAMEK: What volume is that?

MS. KITELY: Volume 64 Mr. Lamek.

MR. LAMEK: Thank you.

Q. Dr. MacLeod highlighted those numbers and suggested to the Commissioner that the important point in the non-unit dose is that the rates range between 8.9 per cent and 14.5 per cent.

Dr. MacLeod further in volume 66, page 4590, suggested that the error rate may be as high as 1 in 200 or 0.5 per cent.

Now I have given you Dr. McGee a series of statistics of lows and highs of medication errors, some including errors as to time and some excluding errors as to time. On the basis of your experience can you comment on the various rates which I have given you?

A. Yes. That is if I can keep straight all the numbers. .5 to 20 per cent that is a very broad range and it is quite conceivable

that error rates were often higher than that given these are all the averages, the averages could be higher than the averages implied in those ranges.

Q. Is there a reason for that?

A. Well the fact that error rates are also a function of accidents and accidents function by chance, so there are times when they could be higher. There also could be times where there are additional variables involved, and more than what all was operating in terms of the error is not clear.

Q. Let's deal for the moment with, we are going to come to what all is happening with respect to the error momentarily.

A. Okay.

Q. First I would like to ask you if you can itemize for us the various locations in which an error can occur.

A. And by error can occur that is a wrong drug gets into a patient?

Q. Yes.

THE COMMISSIONER: Or the wrong amount I would imagine?

Q. Well for purposes of this --- we will say wrong drug and wrong amount.

A. Wrong dose of wrong drug.

Q. Yes, locations at which the errors can occur.

A. Yes, okay. Errors begin at the point of drug production I would say. That is the first point of error is the production of the drug.

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The second point would be its distribution, that is the right drug going to the right distribution centre.

The next class of error would be at the reception from the drug house, the reconstitution and if there is repackaging and relabelling. There are points for error there in the reception centre.

Q. I stop you. You used the term, "Reconstituting". Am I correct that that means if a drug comes into a Hospital Pharmacy in a particular form,but before it is administered it either has to be mixed with something or the strengths has to be changed?

A. In some way, yes.

Q. In either of those that is reconstitution.

A. That is what I mean, yes.

Q. Where is the next possible location of error?

A. The next error is in the pharmacy receiving an order for a drug, in fact, filling it as ordered, so that the wrong drug could be sent out or the wrong dosage could be sent out. That is the particular area I encountered with the morbidity care study.

Q. What is the next location of errors?

A. The next location is, in fact, then on the request for the drug, that is the physician's order for the drug. The right drug has to be ordered in the right dosage, so there is a correct dosage order required and the risk of error is in the order.

The next point, then, is an arranging for the administration of the drug. The drug is ordered and usually it is transcribed so the next point of error is in transcription.

In receiving the requisition of drugs from the pharmacy the availability of the right dose and right drug, and then of preparing the drug for administration, is a risk of error.

Q. All right. Sorry, go ahead.

A. The other two places is the right dosage being administered, in fact, to the right patient.

Q. All right. I'm going to come to the breakdown of the administration function in a moment, but is it fair to say that you are suggesting that there are seven locations in which error can occur: manufacturer, distributor, reception

of pharmacy, distribution by Pharmacy, Physician error, transcription and administration?

A. Right.

Q. Let us deal with the last of those, namely doctor's orders, transcription and administration. Can you identify within those locations of errors the point at which the error can occur?

A. The initial conception of the drug to be ordered and the calculation of the order, that is the right drug being ordered and the right dosage being calculated.

Q. Done by the physician?

A. Correct.

Q. Yes, next?

A. Presuming he documents in his requisition correctly, then is it transcribed correctly.

Q. Yes.

A. If it is transcribed correctly then is it selected correctly, is it prepared correctly and is it administered correctly? Now, in the administration it is not only the right drug, right dosage to the right patient, but also by the right method.

Q. All right. I have added those up as being five general areas in which errors can occur in the context of doctor's orders transcription and administration.

A. Okay.

Q. Now, the next area that I would like to canvass with you is the factors which can contribute to error by nursing personnel.

A. That is after the point of ordering and transcription?

Q. Yes.

A. Yes, and that is where most of the errors have been counted.

Q. Can you help us with what contributes to it at that stage?

A. There are several things. For example, if there is a high rate of drug -- drug orders come in at one time, so sheer volume of orders at any one point in time will increase a risk.

In the mention of transcribing multiple orders, and there is interruption in that process of transcription, the risk of error increases. If there is competition for time; time, attention and vocus of attention, the risk of error will increase. If there is any possibility that the patients you

asked for administration also?

Q. Yes.

A. That the patients are not known to the administrator of the medication, the risk of error increases.

Q. Is there a risk when an emergency situation occurs?

A. Yes, that is under the rubric of competition of vocus of attention. If there is an emergency or multiple distractions of varying severity then the risk is heightened; I would say immeasurably.

Q. Is it fair to say another factor contributing to error in a paediatric setting is that the dosages must be calculated because they are so much smaller than for adults?

A. Yes, that is when I was saying dosage,that is the point that is implied, because frequently the paediatric dosage has to be recalculated in terms of body weight.

Q. Is it fair to say, in summary, that the factors contributing might be the volume of orders?

A. Yes.

Q. The interruptions in

transcription ?

A. Yes.

Q. Competition for time, which would you include? emergencies?

A. And attention, yes.

Q. And the patient not being know to the administrator and dosage calculation?

A. Yes, and recalculation.

Q. Much of what we have heard about is digoxin in this inquiry and the Hospital Manual requires that it be double checked. Can you help us, what is the effect of double checking the drug vis-a-vis the rate of error?

A. It would diminish the risk of error if a drug is double checked in its preparation and administration.

Q. Does it eliminate it?

A. No, decrease the risk.

MS. KITELY: Mr. Registrar, I wonder if the witness might have Exhibit 131, and specifically the boxes of lanoxin. Mr. Commissioner, essentially where I am going is my friend, Ms. Cronk in the course of her examination of Nurse Gloria Bucci at Volume 140, commencing at page 2352 dealt with these boxes of lanoxin

and put a certain scenario to Miss Bucci. I intend to review that evidence with this witness.

THE COMMISSIONER: Excuse me just a moment. The red one is the adult, I take it? These are both lanoxin. Yes, all right, thank you.

MS. KITELY: Q: Dr. McGee, the scenario that was being put to the witness Bucci was a possibility that digoxin or lanoxin, as it is labelled there --

THE COMMISSIONER: We have some more for some reason.

MS. KITELY: We only need the two we have got now.

THE COMMISSIONER: I would think there is more than enough and doubtless will be a medication error somewhere if we keep them around. The Registrar tells me we have a whole box. I think we better keep that well under lock and key.

THE WITNESS: The health care costs are going to go up.

THE COMMISSIONER: Yes.

MS .KITELY: Q: Dr. McGee, the scenario put to the witness Bucci is that there might be a possibility of digoxin being administered instead of a drug called Heparin. Am I correct that you have

read the portion of Mrs. Bucci's evidence which commences at page 2352 and ends at 2365?

A. I have read a portion of the testimony. I don't remember what pages. I will take your word for it.

Q. I can assure you this is the same number of pages you have read. Would you agree with me on that?

A. Yes, I will.

Q. Thank you. Now, I will ask you to assume that you have one box there which is white and it is labelled and the black print indicates paediatric.

A. That is correct.

Q. And the red print indicates adult?

A. Right.

Q. There is dark print on the box indicating so many milligrams per millilitre?

A. Dark print?

Q. The witness Bucci described it as dark print.

A. It may be a little heavier.

Q. Can you point out to the Commissioner where you are referring to on the box or

the boxes you have now?

THE COMMISSIONER: What was the question you said, dark print?

Q. The witness said there was dark print indicating so many milligrams per millilitre.

I am trying to find it on the box for you, sir.

THE COMMISSIONER: If we look at the adult there is certainly dark print I suppose, but in the paediatric it seems to be light print on a dark background.

MS. KITELY: Q: Is that your perception?

A. Yes.

Q. Now, the evidence that was put to Nurse Bucci did not include a box of Heparin, so the only thing we got to go on Heparin is that it may have had heavy and darker lettering. That is the only assumption that I can ask you to make about Heparin. I am going to ask you to assume that the drugs in the medication room for a particular board room were supposed to be stored alphabetically.

THE COMMISSIONER: Did we ever discover what that meant, Mr. Roland, or Miss Thomson? It was filed under digoxin or lanoxin. We don't know

yet?

MR. ROLAND: I think we might have known at one time.

MS. KITELY: Miss Thomson has forgotten.

THE COMMISSIONER: All right, very well.

THE WITNESS: It is another point, a problem isn't it?

THE COMMISSIONER: You might be able to tell us, what is the general rule or do you know?

THE WITNESS: It has changed through the years.

THE COMMISSIONER: Which has changed?

THE WITNESS: Actually in some places they don't store them alphabetically by name. In some places it is generically and in some places by brand. Generic is where in most institutions are held, so there would be some kind of standardization.

MS. KITELY: Mr. Commissioner, I plan now to read three pages from the evidence of Miss Bucci. This is Volume 140, page 2361 to 2364.

THE COMMISSIONER: I'm sorry, what are those pages?

MS. KITELY: 2361 to 2364.

Q. Dr. McGee, this is a scenario about the places in which errors can occur. I am going

to read the evidence to you and then ask you a question. I am reading from the cross-examination of Ms. Cronk and the question:

> "It seems to me in that situation a number of things would have had to have happened in order to make that possible, and I would like to obtain your views and your assistance on it."

THE COMMISSIONER: I'm sorry were we talking there about a mistake between the adult and the paediatric or are we talking about a mistake between Heparin and Digoxin?

MS. KITELY: Heparin and Digoxin was the lead up, sir.

MS. CRONK: I can tell you, sir, there is no Heparin there.

THE COMMISSIONER: There is not much point in looking at it.

MS. KITELY: That came up during the course of Miss Cronk's evidence.

THE COMMISSIONER: All right.

MS. CRONK: Ms. Cronk's examination ?

MS. KITELY: Ms.Cronk's examination, I am sorry.

MR. LAMEK: Is there a difference?

MS. CRONK: I tried.

MS. KITELY: Q: Picking up at page 2361, Dr. McGee:

"It seems to me first, given what we have just looked at, the boxes of digoxin, that someone would have had to take the digoxin from one of those boxes thinking that it was heparin without looking at the lettering on the digoxin box without realizing that despite the lettering and the colouring that they had digoxin instead of heparin?

A. That's right.

Q. They would have had to make that mistake, is that right?

A. Yes.

Q. And as well we have heard in prior evidence from another witness, and we have discussed it this morning, that the drug in those medication rooms were not controlled drugs they were stored alphabetically. So, I am going to suggest to you that someone would have to reach for a box of heparin ampules,

but instead of getting heparin would have to end up in one of two places either under, "D" under for digoxin or at "L" under Lanoxin?

A. Right.

E/EMT/LN
1

"Q. They would have to do that? All right?

A. Yes.

Q. And then thirdly you have told us that the drug would have to be drawn up - in the belief that it was heparin it would have to be drawn up in a 3 cc. syringe as you recall it?

A. Yes.

Q. All right. And in order to do that obviously you would have to open the box containing the ampules of the drug, take out the ampule and physically draw it up in the syringe?

A. Yes.

Q. All right. And you have told us it was your particular practice to always read the lettering on the ampule? Do I have that correctly?

A. Yes.

Q. All right. So that at that stage of the procedure I am going to suggest another mistake would have had to have been made, and that is that the person who made the error would have had to

E2

have taken the ampule out of the box, drawn it up into the 3 cc. syringe and then in the time that took never have read the lettering on the ampule or if they did read it, misread it. That is another mistake that would have to be made, isn't that so?

A. Yes.

Q. And you have also told us, and the policy manual confirms, that we just looked at, that the drawing up of intravenous heparin requires double checking by two nurses?

A. Yes.

Q. All right. So I am going to suggest to you that the three errors that I have just described to you would have had to have been made by two people?

A. Yes.

Q. The second nurse in the room observing the procedure would have had to not detect the error anywhere along the road in that procedure so far?

A. That's right.

E3

Q. And that, by my count, takes us up to six errors at that stage alone, and I am going to suggest one more step to you and I ask you to tell me whether you agree or disagree.

You have told us that heparin, as you recall it, had to be double-signed, and we have explored this afternoon that that could have meant a double signature on the label on the syringe or on an anticoagulation form, although you are not sure it was in use. Whichever it was, I am going to suggest to you then there are another two errors, and that is that the two nurses who signed for the drug, if there were two, had to sign for heparin believing it was heparin when in fact they had digoxin?

A. That's right. "

Now if I can summarize, I gather Ms. Cronk through the witness Bucci was suggesting there was a total of eight errors; first in the mistake in lettering and colour ; second, in the alphabetization or removing from a alphabetized system; thirdly, drawing up; fourth, fifth and sixth, being a repeat

E4

of those by the checker; seventh being a signing by the administrator and eight being signed by the checker.

My question to you is, Dr. McGee, how many errors do you see in that scenario?

A. I am not sure I would have counted eight. I would suggest the notion of the ordering (that is the alphabetizing of the drug and the counting) its selection as an error -- does the procedure manual also say they have to monitor the selecting from the alphabet.

If that's true, then, yes, it's an error, but if it isn't dictated, then it can't be counted as one. I am not sure what the procedure manual reads in terms of what the checker has to check.

THE COMMISSIONER: Oh, I see.

What the checker has to check is the heparin in the syringe and at what dosage, so it is the ampule from which the drug is being drawn that the checker has to check. If she doesn't check it, that's the first error of the checker.

MS. KITELY: Q. Yes.

A. So given that at the point at which there was supposed to have been six or eight, I am counting four.

E5

Q. Can you list the four for us so that we see the difference between them?

A. Well, the administrator of the drug is if there is an error in box selection.

Q. That's one?

A. And if there is an error in ampule selection, and if there is an error in dosage, and the checker, an error in ampule selection. Am I counting correctly?

THE COMMISSIONER: That's four.

MS. KITELY: Q. That adds up to four. Assuming that an error occurred at one of those stages and it is subsequently signed by the administrator and signed by the checker, do you consider those two more errors?

A. The requirement is that they sign. The error was made, if there was an error, it was made in the withdrawing or the loading of the syringe.

The signature is to indicate that it was done and who did it. The absence of a signature would have been an error. A wrong signature would have been an error. The point is it was done, and that is what the signature attests to. So I am not suggesting - I am not ready to suggest that was an error.

E6

Q. So of the eight that Miss Bucci tallied up through her cross-examination by Ms. Cronk, is it fair to say at the most you can see in that scenario is four?

A. It is four, but I would agree that it is compounded.

Q. Now what I would like to do is go back to Dr. MacLeod's error rate, and he postulated an error of wrong dose to wrong patient of 0.5%, you recall a few minutes ago?

A. Yes.

Q. Do you agree with me that most errors are undetected?

A. Yes, I would agree with that.

Q. And at the Hospital for Sick Children during the period of time that we are interested in when an error was detected an incident report had to be completed?

A. Had to be completed. That's usual.

Q. I'm going to ask you to assume from the evidence that Dr. MacLeod gave us (this is the same excerpt that I referred to earlier, sir) that there was as many as 800 medications per day on wards 4A and 4B. Would you make that assumption just for now?

A. Yes.

Q. Would you agree with me that if we applied Dr. MacLeod's error rate of 0.5% and if all errors were detected and recorded on incident reports, that the mathematics would indicate we would have as many as four incident reports per day?

A. It may run that average, yes.

Q. And if one multiplies that by nine months we would have an excess of 1000 incident reports?

A. If the average held.

MS. KITELY: Now I would like to go to the third area, sir; namely that of several aspects of charting. I would ask that the witness be given Exhibit 307.

While you are up, Mr. Registrar, Exhibit 115?

Now the kind of reporting that was done in the Hospital during the period that we are interested in, Dr. McGee, was something called POMR or problem oriented medical reporting.

Are you familiar with that system?

A. Yes.

Q. And part of the system requires that Exhibit 307 be completed which was a patient care

plan. Do you have one of those in front of you?

A. Yes.

Q. And I note that on the front of the patient care plan there is a category of special points to observe, and on the back a category of unusual problems.

Could you help us with how a nurse would complete a sample of Exhibit 307 in the context of problem oriented medical reporting?

A. Yes. The special points to observe - this is the part that you -

Q. On the front, yes.

A. To relate to the unusual problem.

Q. How you distinguish between them and how they relate to the system of problem oriented medical reporting.

A. Yes, the problems are going to have major indicators or major mechanisms to monitor and the special points to observe would be one way of highlighting those dimensions that the care givers would want to monitor.

Q. Can you give us an example, Dr. McGee?

A. Well, someone with a fracture is going to have his extremities monitored for colour

E9

and temperature and so on to make sure there are no problems so it would be colour.

Q. So under special points to observe we would see colour?

A. Yes.

Q. What would we see under unusual problems?

A. Some relationship with the fracture.

Q. Now at the Hospital for Sick Children during the period in question these were not maintained as a permanent part of the record. They were eliminated at a certain point in time.

Do you have a comment on that?

A. Well, I think they lose data when they don't retain them. I think it is a method of monitoring not only actions that were carried out but the way that care providers are thinking on a day to day basis, so I always think it's a loss to lose these contents.

A. And we have also heard evidence that when Exhibit 307 was prepared in fact it was updated during the course of the patient's stay in Hospital.

A. I would expect so.

E10

Q. And the updating went along with the progress of the child?

A. Yes.

Q. Can you comment on the system whereby a change would be made on the document and something rubbed out and something else put on the paper. Can you comment on that system?

A. Well, it probably was an inexpensive way to do the monitoring. I think that if there has been a change, then the change should be added. It should be an addendum rather than a modification of what the document says.

Since the pages aren't retained, I guess many of the care givers, nurses, physicians, don't handle it like a permanent document so they do change things. It saves getting another page.

Q. Is that a practical -

A. It is a practical solution. They would probably be drowned in paper if they didn't do that, but the point is it is still a useful record especially in a retrospective kind of analysis.

Q. Now can I ask you to look at Exhibit 115 which is the chart of Baby Miller, and turn to page 42. And if you will look at the entry on March 20th, from 1900 hours to 0300 hours?

E11

A. Yes.

Q. There are listed there three headings and comments after each.

Can you comment on that particular nursing note in the context of problem oriented medical reporting?

Now am I correct it is the heading under apex?

A. Yes. BP.

Q. That's the first one I meant.

A. Yes. Those are the points to observe.

Q. So that going back to Exhibit 307 under special points to observe on the front, there would have been listed apex, BP, check colour, behaviour, nutrition?

A. Those are the indicators they are using and in the order of expected - it is an expected ordering.

Q. Is there some priorizing in that list?

A. It is probably in the order of dominance. That is the apex, BP, blood pressure, chest, colour, those are the first things one would look at. Behaviour and nutrition are things that

E1 2

must be monitored, especially in babies, especially in nutritional intake and output are monitored. So it's in the order - it is rather in an order of importance.

Q. Now I would ask you to look at Exhibit 154 which you should have in front of you, that being a document called Fluid Record Work Sheet?

A. Yes.

Q. And the evidence that we have heard indicates that this document was kept by the bedside. Are you familiar with such a system?

A. It is a variation on a theme. Usually there is some kind of fluid balance sheets are kept especially in paediatrics.

Q. We have heard evidence that these work sheets like the patient care plan do not form part of the patient's record. They too are disposed of?

A. Yes, that's usual too.

Q. And can you comment on that system; namely the disposing of the immediate record by the bedside?

A. Well, there are points - for example if they are disposed of it means someone has had to transcribe the results to a permanent record so I think that is an extra expenditure of time.

DM/ac
F-1

The other things is that it is a document, an ongoing document, and to me it is useful to be retained.

MR. ROLAND: Mr. Commissioner, I didn't think we were going to get into this sort of thing. You know, if this witness is going to be led through a lot of nursing practices in the Hospital at the time, and charting practices and so on, and say I presume for the purposes of recommending that some changes take place in the Hospital. First of all, that was three years ago and there are competing interests in all of this. If we are going to get into this sort of examination. I thought that your ruling made it clear, at least implicitly, that this was not the sort of evidence that we were going to get into.

THE COMMISSIONER: Ms. Kitely how does this help us?

MS. KITELY: Well Mr. Commissioner if I can - the whole point in dealing with this particular part of the evidence is the accuracy of nursing observations, and that was gone into in great detail by some of my friends.

THE COMMISSIONER: I know, but the charting system itself how does that assist us?

DM-ac

F-2

MS. KITELY: Well, for example --

THE COMMISSIONER: If the charting system was good or bad at the time, how will it help us with the cause of death?

MS. KITELY: Well Mr. Commissioner, if many nurses had not been asked about the charting I would not say that it has anything to do with the cause of death. But to the extent they were all asked about their charting ipso facto it must have something to do with the cause of death. If my friend will withhold his objection I have literally one more question on this area then I plan to move on.

MR. ROLAND: My problem is that my friend is insidious in this, and she has asked the question, she asked it about the sheet and I had no objection about that, it is explaining a sheet that is kept and used. And then she asked the witness to give an opinion on whether or not this is a proper procedure or not; should it be transcribed or not; should it be kept or not. There are competing interests in all of that and I can call evidence about why the practice was done the way it was and what the competing interests are. It does not get us anywhere expect it

is going to mean, I presume my friend by calling evidence will ask you to make some recommendation about all this, I think beyond your mandate.

THE COMMISSIONER: If you could just - I will ask Dr. McGee not to answer, could you just give us your last question now.

MS. KITELY: Yes, I am going back to Exhibit 115 and it is with respect to page 42 of the chart and I asked her about -

THE COMMISSIONER: Page 42?

MS. KITELY: Yes. It is what we looked at earlier and I omitted one question. She indicated that the items are listed there in some sort of priority. My question to her was; nutrition is the last item that was recorded, does that necessarily mean that 50 cc. of apple juice at 2100 hours was the last thing that was necessarily done to the child during that period of charting?

MR. LAMEK: Is that a question that Dr. McGee can answer?

THE COMMISSIONER: I don't understand it, I really don't quite understand the question.

MS. KITELY: She has indicated that it was recorded in priorities with respect to

Exhibit 307.

THE COMMISSIONER: You mean whether these are consecutive?

MS. KITELY: That is right, sir. They may be recorded in a particular way but they may not have occurred in a particular way, and in my submission it is a question that on her knowledge of recording --

THE COMMISSIONER: There's nothing wrong with that is there?

MR. ROLAND: No, I don't find anything wrong with it, I thought this was a question that should have been asked of Susan Nelles.

THE COMMISSIONER: It would have been better perhaps she certainly would have helped us by telling us whether she generally did things - I would think it unlikely because she has got it under Headings, and it is unlikely - however, I don't see anything wrong with that question.

MS. KITELY: Thank you, sir.

Q. If I could put the question again Dr. McGee. Looking at page 42 of Exhibit 115 we see that nutrition is the last item.

A. Yes.

Q. Is it fair to say because it is the last item does not mean it was the last function performed to this child?

THE COMMISSIONER: Would you put the necessarily in there, not necesarily. All right, go ahead, I will leave it with you, let Dr. McGee answer it.

Q. If we assume that Exhibit 307 required for special points to have served, to be listed as you indicated in some sort of priority, is it a fair assumption that nutrition was the last item of priority?

A. The probability is that the least important would be last.

Q. And because it is last, it doesn't mean that the description of the action in tolerating 50 cc. of apple juice was the last function performed for the particular patient during the period reported?

A. Not necessarily.

MS. KITELY: Mr. Commissioner I intend to go on to my fourth area.

THE COMMISSIONER: All right. I think we will take 20 minutes then.

---(Short Recess)

DM/ac

F.2.1.

---(Upon Resuming)

THE COMMISSIONER: Yes Miss Kitely?

MS. KITELY: Yes, sir. I indicated to you that the last issue I planned to deal with was a series of hypotheticals, but before I actually get to the hypotheticals I have two questions I would like to put.

Q. First of all, Dr. McGee, can you help us with, on the basis of your experience, can you define the nursing role in a paediatric setting?

A. Yes. I presume you want a moderately brief answer?

Q. I suspect there are books written on the subject.

A. That is correct.

Q. And I am not wanting a book.

A. Yes. The nursing role, the nursing mission maybe is an even better way of talking about it. The idea of nursing is really to meld both the art and the science under the health care. So the main role, the mission really must address the monitoring, the care needed for the business

of day to day existence. The care needed for the handling of the problem for which the patient is there in the first place. The support and organizing of the day to day activities of the system that surrounded those issues, the focus of attention; the focus of attention being of course the patient, and in paediatrics I think you have mentioned that we are talking about a paediatric area, then equally important is the family of the patient. The nurses' mission is going to be addressing the needs by the monitoring, the care, the task ordering, the system function in the area which includes the family, and its needs in terms of this patient, and the patient.

Q. And is it fair to say that an element of his monitoring is to watch the progress of a child, and infant, in order to predict progress and to anticipate difficulties?

A. I would hope, yes.

Q. Now in the Hospital for Sick Children during the time that we are interested in, they use the approach of team nursing. I understand there are as many as 20 different approaches, theoretical approaches to nursing. Is it fair to say that for our purposes we can compare primary

nursing on the one hand and team nursing on the other?

A. And even if within those 20 models of nursing might subsume both team and primary. In other words that is an organization of the system, as well as an approach to the patient.

Q. If we can deal with the essence of team nursing.

A. Surely.

Q. And if you can help me with the areas in which the members of a team would collaborate with each other in order to perform their nursing function.

A. Surely. Yes, in that respect team nursing as opposed to solo care, or one-to-one care frequently, in fact most frequently, members of a health care set, setting, are organized into teams. Sometimes they are the same discipline and sometimes there is more than one discipline on a team. The notion is to organize the care to be given to groups of patients and it offers a backup; it offers assurance that care is given, that there is support, there is availability for consulting about problems, as well as supplying extra manpower when it

is necessary.

Q. Is it fair to say that one of the concerns about team nursing is to ensure an equity of distribution of workload so that a particular member of a team is not overworked and another member of the team is underworked?

A. It has that advantage. It distributes the workload for the care givers and it also increases the probability of care being given to all of the patients and people.

Q. And dealing with the members of the team, assuming for the moment that the teams that we are dealing with are composed of RN's and RNA's.

A. Yes.

Q. Is it fair to say that there is collaboration between the two of them so if, for example an RN was assigned to the care of two patients, and an RNA for maybe four patients, that the RNA might perform some functions for the RN and her patients?

A. Sure.

Q. Such as feeding?

A. Feeding.

Q. Bathing?

A. The daily type -

Q. Measuring input and output?

A. That kind of thing.

Q. And on the other hand the RN might perform certain functions for the RNA such as administering medication?

A. Right.

Q. And in concerned circumstances the RN or RNA would cover for each other and do relief over the lunch hour and breaks?

A. It is possible, depending on the status of the patients of course, because needless to say you are not going to assign a very ill baby to an RNA.

Q. And am I correct that given that this is the approach to nursing on a particular ward, is it to be anticipated that when the progress note is written --

A. Yes.

Q. That there will be an element of collaboration between members of the team in recording what was done for that particular patient?

A. It would indicate that There is going to be collaboration from the point of distributing the indentification and completion of the task to be done, as well as collaborating in progress, and collaborating, divvying up what gets documented.

Q. So, for example, if a particular nurse was assigned to a patient, and another nurse during a period of relief did something such as feed the child and measure the input.

A. Yes.

Q. The second one would report to the first one and in fact the first one would likely record it in the progress note?

A. Might well do the documenting, especially on those tasks that have to do with the business of living, that is feeding and sleeping.

Q. Now you have seen the ward itself in Exhibit 304, which is the diagram of the ward. It is essentially a Y-shape, and would you agree with me that in a situation such as that that another area of collaboration that would be expected that the staff from one side would respond to a crises

situations on the other?

A. That is usual.

MS. KITELY: Now Mr. Commissioner what I next plan to do is put to this witness a series of six scenarios and in each case --

MR. OLAH: Mr. Commissioner I am a little concerned about some of the hypotheticals my friend is putting about collaboration about RNA's with nurses --

THE COMMISSIONER: We haven't put any yet.

MR. OLAH: Well I am just wondering when we have specific evidence of what functions were being discharged and we have had a whole host of it. I am not sure how a hypothetical, certainly with respect to some of the areas my friend has touched on,really assist us.

THE COMMISSIONER: The hypothetical question is only as good as the hypothesis. So you just have to wait and see what hypothesis you can put, and if the hypothesis doesn't correspond with the fact it doesn't help us.

MS. KITELY: I agree, sir, but that is what I was about to do though.

RD/hr

THE COMMISSIONER: There you are. You will have an opportunity. If you think it doesn't correspond with the hypothesis, you change the hypothesis and maybe get a different answer or maybe get the same answer, I don't know.

MS. KITELY: Thank you, sir.

Q. You may need a piece of paper and a pencil to make the odd notation. Do you have those commodities? The Registrar can assist you.

Dr. McGee, I am going to ask you to assume certain facts. First of all, assume you have a team leader and secondly that her role is, as described in Exhibit 342.

Mr. Registrar, would you show the witness Exhibit 342.

You referred to this earlier and you indicated --

A. Yes, I remember.

Q. I ask you to assume that this team leader functioned in that capacity on a particular ward for about a year. Please assume that during a nine month period there were 27 deaths on the ward, of which approximately 18 were under the age of three months.

THE COMMISSIONER: 27.

Q. 27 of which 18 were under three months old at the time of the death.

Please assume that when this team leader is questioned three years later about the deaths during that period she has no recollection of many of the children and, finally assume that she does have a recolllection of some of the parents. My question to you is --

THE COMMISSIONER: I'm sorry, she has no recollection of what, did you say?

MS. KITELY: She has no recollection of many of the children and, lastly, she does have a recollection of some of the parents.

THE COMMISSIONER: Yes.

Q. Dr. McGee, my question to you is: do you regard the recollection of that team leader functioning in that setting as usual or unusual?

THE COMMISSIONER: No, I think that isn't possible. Miss. Kitely, you see this is a good question for a psychologist, I suppose, or a psychiatrist but even those we don't allow them in the court. You see, credibility is a question for the decider of facts.

MS. KITELY: Mr. Commissioner, if you

willallow the witness to answer the question you will see the importance of the answer. If I might, sir, the witness' have been judged with respect to there functioning in a certain setting. We have established, in my submission, beyond question, that this witness is an expert in that setting.

THE COMMISSIONER: Yes. That is true. What you are, in effect, asking me to do, is to decide -- you are asking Dr. McGee to decide whether or not I am to believe Mrs. Trayner.Is that what you are asking?

MS. KITELY: No, that's not what I am asking you to do.

THE COMMISSIONER: I'm sorry.

MS. KITELY: I am asking Dr. McGee to say that if there was a given nurse in this given hypothetical situation it is her recollection --

THE COMMISSIONER: They would all be different. Every nurse would be different. We have seen that. Some nurses remember better than others and some don't.

MS. KITELY: But, Mr. Commissioner, the question put to her was: is it usual or unusual. I think if she is allowed to answer the question she can deal with the concern of your question.

THE COMMISSIONER: I don't know. I

don't want to fight this battle alone. If somebody else cares -- do you care, Mr. Lamek?

MS. CRONK: I will get up, too.

MS. KITELY: We don't have to make it two on one.

MR. LAMEK: This hypothetical team leader is really not very much help to anybody. We are talking about real people with a given set of characteristics and a given set of stress and recollection and all the rest of it. What a hypothetical question designed to elicit whether something is usual or unusual can do, I confess is beyond me.

THE COMMISSIONER: Anyone else?

MR. ROLAND: I agree with Mr. Lamek. I don't think this witness is an expert for this question, in any event. I don't know how anybody could be an expert on it without having heard the evidence from Phyllis Trayner and the only expert on that issue is you, because you are the only one to decide the credibility. But this witness, it doesn't seem to me is an expert, in any event, even on Ms. Kitely's scenario. She hasn't been a team leader on a ward like this where 27 babies have died over a nine month period from what I understand.

THE COMMISSIONER: A real expert, of

course, would be Mrs. Trayner.

MR. ROLAND: Mrs. Trayner is the best expert and the second expert is someone who has been in that same situation.

MS. KITELY: Mr. Commissioner, we don't have someone who has been in that situation.

MR. YOUNG: We heard from Mrs. Trayner.

THE COMMISSIONER: We heard from Mrs. Trayner. We had heard that she was in that position. We heard from her and she said that she didn't remember.

MS. KITELY: I was referring to my friend's second best alternative, which was someone else who was there. In my submission, it is important that if this Commission is going to hear evidence of certain practices and context --

THE COMMISSIONER: If we had heard from someone it would be some basis for this. If someone had come into the stand and said, well, if I had been - some expert, let's say, nurse or someone like that, who said that if I had been in these circumstances I would have remembered every solitary baby. If someone said that then perhaps there would be some justification. We wouldn't allow that kind of evidence either.

MS. KITELY: Mr. Commissioner, the whole point of having an expert is to be not individualized.

THE COMMISSIONER: That's right, we don't have experts in credibility. That still is the trier of fact.

MS. KITELY: Mr. Commissioner, this witness is not put forward to say whether this hypothetical team leader was lying or was not lying. That is what credibility is.

THE COMMISSIONER: What is she there to say? Whether it is likely she would be lying or not?

MS. KITELY: No she is not, sir. She is being put forward to say whether or not a nurse functioning in that setting would, for certain reasons,which if she will be allowed to give them, she can expound upon, remember parents as opposed to children. There is a rational, sir, and I would ask you to bear with me long enough to let her answer the question.

THE COMMISSIONER: I should not be telling you how to conduct your case, but it might conceivably been better if you had said: are there factors that might indicate that a nurse might or might

not in certain circumstances remember nurses -- remember parents instead of children.

MS. KITELY: I am prepared to change the question, sir. I am forever flexible.

THE COMMISSIONER: I don't know. As junior counsel of the Registered Nurses Association, do you object to that? Not you, Mr. Roland.

MR. ROLAND: If that is the question I don't have any objection to it.

THE COMMISSIONER: All right. Let's give up scenario one and rephrase your question then.

MS. KITELY: Well, what I would like to do is put the question in the context of a scenario.

THE COMMISSIONER: We can't. How about that for a ruling? You can't do it because what you are doing is you are trying to ask Dr. McGee to take over my job. I would be edlighted if she would but I am not allowed to do that, at least not yet, I am allowed to do that. We will see what happens. So she can't do that. She can't decide credibility for me.

MR. ROLAND: That sounds like a ruling, sir.

THE COMMISSIONER: That is a ruling, yes.

MS. KITELY: All right, sir.

Q. Dr. McGee, could you help me with whether there are factors that would affect the recollection of a team leader on a paediatric ward?

A. On a paediatric ward with young babies?

Q. Yes.

A. Yes, I would expect young babies as opposed to older children, or adults interact differently with the care providers, in that babies don't answer questions or identify themselves with particular characteristics. In other words, babies do look a like. They behave very much alike in the beginning of their life. They don't take on as rapidly, especially when there are many of them together. They don't take on individualizing attributes, so someone who is with the baby constantly identifies attributes, but someone who is not with the babies constantly, or particular babies constantly, would be at risk of not recalling those babies, but I would expect that they would recall those about them, with whom they interacted.

Q. Which was?

A. I would expect their families,

it seems to me, in my experience, that there were families which were always part of a paediatric ward, and so that a team leader would have much higher interaction rate with families than with children and interaction rate. It is not that she wouldn't be seeing those babies, but she would be interacting with the families and that helps you remember.

THE COMMISSIONER: How many scenarios did we get rid of that time?

MS. KITELY: Just the one.

THE COMMISSIONER: I am sorry.

Q. Dr. McGee, might I suggest in anticipation of my friends jumping up that you not answer the question until I give my friends an opportunity?

A. Surely.

Q. The next one, Dr. McGee. Can you make these assumptions? First of all, a 12 hour shift commencing at 7:00 p.m. The staff nurse assigned to patient X in room 423, if you have a diagram of the Hospital, and a team leader. Patient Y is admitted at 2230 and a staff nurse is assigned to that child, which was put in room 418. A staff nurse is required to spend considerable time with

patient Y. At 0100 hours patient X is supposed to receive an antibiotic, which is distributed in the Hospital by the pharmacy in vial form. Antibiotics do not have to be checked by a second Registered Nurse. At 0100 hours the team leader draws a syringe takes the med ticket, the syringe and the empty vial The staff nurse in room 418 --

THE COMMISSIONER: What's the question? Is it a likely story? Is this the way it is going to end up?

MS. KITELY: That is not the question, sir. I am almost finished with the hypothetical.

THE COMMISSIONER: All right.

MS. KITELY: Q. Takes a syringe and empty vial to the staff nurse in room 418 and shows them to her and says that she will give medication to patient X. That is the question or the assumption to Dr. McGee.

I will pose the question and this is where you should pause. In your opinion are the team leaders actions in that setting remarkable?

THE COMMISSIONER: Remarkable?

MS. KITELY: How is that for a word, sir?

THE COMMISSIONER: Well --

MS. KITELY: I don't hear an objection, sir.

THE COMMISSIONER: No, no. I think the wheels are grinding at the moment. You mean is it a reasonable thing for her to do?

MS. KITELY: I chose the word remarkable. If you would like to use the word , "reasonable thing to do", then I will substitute it.

THE COMMISSIONER: Well, I don't know why you phrase them the way you do, because phrasing in the way you do you are bound to breach the rules and the rules are that credibility is decided by the finder of fact and so you don't do that. You can certainly ask about the practice of team leaders; do they occasionally, are they supposed to help out their staff when they are busy with somebody else, is it perfectly reasonable for them to go and do that. The minute you put the scenario before me you are really, in fact, asking Dr.McGee, tell me whether Mrs. Trayner is telling the truth or not.

MS. KITELY: No, sir, I'm not.

THE COMMISSIONER: I thought you were. I'm sorry.

MS. KITELY: Absolutely not. All I am asking Dr. McGee to do is to comment on the scenario and

I will use reasonableness if you like, although remarkable was the word I started with. This question is not directed to credibility in any way--

THE COMMISSIONER: Has anyone have any objections?

MS. CECCHETTO: This is very clearly the incident involving --

THE COMMISSIONER: Yes, you don't need to tell me what the incident is. I got that at the second one.

MS. KITELY: Hypothetical, sir.

MS. CECCHETTO: The problem with that, sir, really is if the only purpose is to get the witness to comment that it isn't remarkable, then obviously it is a comment on credibility and if in cross-examination we are then not allowed to put all the other various hypotheticals and brand them as hypotheticals, really there is no way that this is of any assistance other than a common --

THE COMMISSIONER: We are going to go through this --

MS. KITELY: Five more times, sir.

THE COMMISSIONER: Five more times. It is a little early to go to lunch. I would like you to revise all of these questions. Maybe you can

do them right now.

MS. KITELY: Mr. Commissioner --

THE COMMISSIONER: The minute you get so precise in this scenario then you are asking that very question that sometime I may or may not have to decide.

MS. KITELY: I can change the question as I go along, sir. I don't have difficulty with that but with all due respect, we heard hours of evidence trying to make certain individuals precise as to time.

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If I were to give you a hypothetical that was not precise at the time I am sure that some of my friends would be on their feet.

THE COMMISSIONER: All you are trying to show - all you are trying to show from this is that there is nothing unusual about a team leader under these circumstances drawing up the medicine, showing the syringe and showing the empty vial to the nurse. Isn't that what you are trying to establish?

MS. KITELY: I am trying to establish whether it is reasonable nursing practice.

MR. ROLAND: Well, Mr. Commissioner, if we recall the evidence - this is what concerns me about the question - if we recall the evidence of Phyllis Trayner and Susan Nelles, both of them said this was remarkable; remarkable in the sense that it had never occurred before for gentamicin.

Susan Nelles as I recall said Phyllis Trayner had never done this sort of thing before with her. Phyllis Trayner said she had never done it before, and then gave her explanation for doing it this time.

So the evidence we have from the two participants in the scenario themselves, they both said this incident was in their experience between

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themselves on that ward in nine months remarkable. And I would have thought that - it is interesting the witness calling this witness now to say, I presume, that wasn't very remarkable when the two actors themselves have said in their own life on that ward it was a remarkable experience.

MS. KITELY: Mr. Commissioner, I don't wish to suggest that we ought to have a battle on the next five of these. I am prepared to change the question to given that scenario - in my submission the scenario is important to the question - does it illustrate reasonable nursing practice?

MR. LAMEK: Mr. Commissioner, I am sorry, but my friend Mr. Roland has put his finger on something and it is very important. The explanation that we have heard from a participant in this, Mrs. Trayner, was one which needs to be put as part of that hypothetical before any sense or comment will be made upon the appropriateness of her - even if such comment is permissible, the objectives that Mrs. Trayner says she was trying to achieve would be a very important part of this situation for Dr. McGee's consideration.

MS. KITELY: Mr. Commissioner, I have built the assumption in such a way to not offend the

various interests. I assume I was doing that. In my submission the assumptions I put to her followed by the question to the Doctor, do you consider this reasonable nursing practice an appropriate question.

THE COMMISSIONER: I'm going to rule against you on this one, Miss Kitely. It seems to be nothing more than a suggestion to the witness to help me on the question of credibility. However much I would like it I can't allow that. There you are. Now you can revise the question if you want to or go onto the next one and I will rule on that.

MS. KITELY: I thought I had revised it sir, to be consistent with your comment; namely is a team leader's action consistent with good nursing practice? Is there a difficulty with that question?

THE COMMISSIONER: Well, it is not good nursing practice - it might well be perfectly reasonable for the team leader to do what she did, but the problem I am faced with has nothing to do with whether it is good nursing practice or not. The problem that I have to deal with, if I had to deal with it, is what was happening in that ward at that particular time?

MS. KITELY: Mr. Commissioner, you started this out by saying that the answer is only

as good as the hypothetical that is put to the witness.

THE COMMISSIONER: Yes.

H4 MS. KITELY: And in my submission this is a fair hypothetical and a fair question. If you in your ultimate judgment find it is not, then it is up to you but in my submission it would expediate matters so that we could deal with the scenario.

THE COMMISSIONER: I have to rule against you on that.

MS. KITELY: So the question, given the scenario, does it constitute good nursing practice, you are disallowing?

THE COMMISSIONER: Yes.

MS. KITELY: May I have a moment, sir?

THE COMMISSIONER: Yes.

MS. KITELY: Q. Dr. McGee, pause before you answer this question and give my friends an opportunity to speak - if using that scenario, namely, that the team leader was going to administer an antibiotic for a member of her team who was otherwise occupied, can you describe the steps using Exhibit 304, and the diagram of the Hospital that she would go through?

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THE COMMISSIONER: I'm sorry, if she were what?

MS. KITELY: If she were administering an antibiotic.

THE COMMISSIONER: Yes.

MS. KITELY: For another nurse.

THE COMMISSIONER: Yes.

MS. KITELY: Who was otherwise occupied what steps would she go through?

Surely there can't be a problem with that.

THE COMMISSIONER: No,I don't think - it might look that way, but I agree with you that there can't really be a problem but -

MR. ROLAND: I assume the question is in accordance with good nursing practice?

THE COMMISSIONER: Yes.

MS. KITELY: Yes.

MR. ROLAND: What steps she would follow?

THE COMMISSIONER: Yes. That's fine.

MS. KITELY: Q. Do you have the question, Dr. McGee?

A. I hope so.

MR. LAMEK: Have you got the answer?

THE WITNESS: I would expect that the

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team leader who was substituting in this task for someone else would check the order, would take the medication ticket, pull the drug, prepare the drug, take the package (that is the vial , the syringe) the necessary aseptic additional equipment she has to take with her to prepare the site, to whoever is ultimately - who was assigned to give the drug initially. In other words the person for whom she is substituting for double checking, and this is for two reasons; to inform that nurse that she is in fact giving that drug. It is really by way of informing more than checking, so there won't be the risk of doing it twice.

MS. KITELY: Q.Is there any advantage to the team leader who was doing the substitution collecting the paraphernalia from the medication room and showing that to the person who ought to be doing the administration and then go to the patient's room, using Exhibit 304?

A. Yes, in other words the in line would be to pick the materials up, go into 418 and then on to 423. Otherwise it is into 418, back to the medication room and then to 423, so it is slightly more efficient.

THE COMMISSIONER: More efficient to do

what?

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THE WITNESS: To pick the materials up, go to 418, then proceed on.

THE COMMISSIONER: You mean rather than to go and do it first and then tell them afterwards?

THE WITNESS: No, the other way around. If she told her first and then went back she would be doubling back.

THE COMMISSION: Oh, I see. She made that accessible to - I didn't think that was what Miss Kitely's question was. I thought the question was it was accessible to take the syringe and the vial and all that and show it to the nurse who was supposed to do it.

MS. KITELY: I didn't quite ask that direct question. I was asking a more general one, but in the context of the -

THE WITNESS: I have them picking it up and showing it to the nurse.

THE COMMISSIONER: Rather than informing -

THE WITNESS: Rather than informing her and then going back. The reason for telling her one of the major reasons is so that the drug won't be given twice. She needs to know that her medication has been given for her.

THE COMMISSIONER: Surely it depends where she is coming from. If she happens to be coming - if she decides she has to go and do it then she would be passing room 418. She would go in and say I am to prepare - I am going to do it and then she would go on to the medication room and then go back. Any of those things.

But you see the problem with all this, Miss Kitely, is you have got this great expert on nursing, and it seems to me that you are asking her many of these questions that a 5 year old child could answer, because I know that it is sensible to save steps. I don't always do it myself, but certainly it would be sensible to do that. But isn't this argument? Isn't this argument? How does it affect your clients?

MS. KITELY: I was just wondering when you were going to come to that.

THE COMMISSIONER: How does it affect your client? That's the problem. Neither Phyllis Trayner nor Susan Nelles are your clients.

MS. KITELY: That is absolutely correct. You remember, sir, we have two sets of clients. On the one hand 39 individual nurses.

THE COMMISSIONER: Yes.

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MS. KITELY: And on the other hand -

THE COMMISSIONER: None of them are affected in this.

MS. KITELY: Not in this particular scenario, that's correct, sir, they are not but we also represent 42,000 registered nurses in the Province of Ontario. And to the extent that nursing evidence and nursing witnesses -

THE COMMISSIONER: I don't quite understand how 42,000 nurses, how you could expect anything that is said against one nurse - if one nurse is performing something that is quite outside the scope of nursing - if a nurse is arrested for drunken driving is that a matter of concern for the Nurses Association?

MS. KITELY: That is not what we are talking about.

THE COMMISSIONER: No, you're quite right. We are talking about something quite worse, quite a bit worse. But how does that become a concern of the Registered Nurses Association? I know that we don't agree on it, Miss Kitely. No doubt they are your clients and no doubt they have instructed you, and I find it hard to understand how they have taken this approach. But however, they are not your

clients and that's another problem.

MS. KITELY: We don't hear any objection from them, sir.

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THE COMMISSIONER: Well, hardly. They would hardly object because it is in their interest. But surely would it not be appropriate to examine on the question?

MS. KITELY: Mr. Commissioner, it is up to them what questions they put. In my submission it is up to us which questions we put.

THE COMMISSIONER: Yes. All right. But at any rate you have had your answer to that one so we can now go ahead.

MS. KITELY: All right.

Q. I am going to ask you to assume that in a particular paediatric ward that in a period of 30 days the ward experiences four deaths. I ask you to assume the staff members become aware that a Coroner has been appointed to consider the death of the third of those children.

My question to you is would you anticipate that the staff members would voice their concerns about the third child to the Coroner.

MR. YOUNG: It is my turn I guess.

MS. KITELY: I didn't know Mr. Young

was acting for the Coroner.

MR. YOUNG: No, I am trying to save my clients and the public some money.

Mr. Commissioner, I have trouble with all these questions. I have trouble with all of them, but this particular question, sir, would it not depend on the terminal events that followed - that accompanied these deaths? Would it not depend on the deceased child and the children's condition prior to death?

THE COMMISSIONER: Well, it depends on a lot of things. It might also depend I suppose, if I take Miss Kitely's side on how ambitious the nurse was to continue in the employment of the Hospital.

MR. YOUNG: Well, that may be another factor.

THE COMMISSIONER: All of those things might well affect it.

MR. YOUNG: I don't think Dr. McGee can address any of these factors any more than you can, sir.

THE COMMISSIONER: Well there you are. Is it likely that a nurse would under those circumstances go to the Coroner having heard that and express her concerns about the cause of death? Is that really what -

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MS. KITELY: That was what the question was before I changed it. I am quite happy if that's the way you want it to be put.

MS. CECCHETTO: In fairness, sir, then I suppose Ms. Kitely would have no objection if in cross-examination it was also put to the witness that there was great concern over this third death, that there were mortality and morbidity reviews; there was an increase in deaths, that there was a question about splitting up nursing teams, if she has no objection to that type of hypothetical question being put, I have no objection to her hypothetical.

THE COMMISSIONER: I just wonder if I could shorten it by saying that if I were a nurse I probably wouldn't go to the Coroner.

MS. KITELY: Q. Dr. McGee would you agree with the Commissioner?

A. I would, of course.

THE COMMISSIONER: I might fret about it but I doubt that I would go.

MS. KITELY: Mr. Commissioner, could I ask you the next question?

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Q. Now let's assume, Dr. McGee that you have got the same one; this is still the same scenario, sir, this is parts A and B.

THE COMMISSIONER: I am prepared.

Q. Dr. McGee, assume you have got the same ward and assume that you have got the same 4 deaths. Assume that the nurse has raised some concerns about the deaths. The question is, would you split up the team that was in charge of the care of these patients?

MR. LAMEK: With those facts, can you get an opinion, of what possible value, Mr. Commissioner.

MS. KITELY: I'm sorry, I didn't hear my friend.

THE COMMISSIONER: He says the facts are a little inadequate that is what he is suggesting.

MR. LAMEK: To make any kind of an opinion.

THE COMMISSIONER: We have spent days and days and days on the question and the problems that were existing with this team, and in fact, in all of the deaths and it had something to do with the difficulties they were getting into and the question of whether the team was changed. Surely , isn't it another thing, what difference does it make ·

MS. KITELY: All right. I will put the question differently, sir, how is that.

Q. If, Dr. McGee, you had a series of deaths on a particular ward; and if you were considering ways of dealing with those deaths, would one of the ways of dealing with it be to split up the team, that cared for the patients who died?

MR. ROLAND: We are just going to keep objecting to these. Mr. Commissioner, your job, as I understand it and I keep repeating it is to decide how these babies died. Whether the team might or might not have been split up, the fact is it wasn't split up, the deaths continued and it wasn't split up. There were discussions both ways on whether it should be split up. The fact of the matter is that it wasn't split up and that is the historical factual background you have to decide on this matter.

THE COMMISSIONER: I would like to be able to - Dr. McGee, there are other ways to answer this question, she is going to get into trouble with some nurses I think at the Hospital for Sick Children, because half of them said that it should be split up and the other half said it should not.

MS. KITELY: Dr. McGee is not being asked on a personal level, Mr. Commissioner, she is

being asked on the basis of her experience. With the greatest of respect she does have some input on this issue.

THE COMMISSIONER: All right, I will allow this question, and the question is only as good as the hypothesis.

MS. KITELY: I will state the question, sir.

THE COMMISSIONER: Mr. Lamek can add some factors to it if he feels like it. All right.

Q. Dr. McGee we have a ward with a team; we have four deaths. The four deaths are coincidental with that team. Can you help us with if from a nursing administration point of view, if you were considering concerns arising out of those deaths, whether you would consider one possibility to split up the team?

A. Not on the basis of the day to day routine.

Q. Why not?

A. Because as with any kind of team performance the notion of team is even learning, and a team is really not complete until it has existed for sometime, which includes hard times and easy times. It would be improper to, on the basis

of just that amount, this amount of deaths to come to the conclusion that it required splitting.

Q . Moving to the next one, sir. I am asking you to assume that we have a team leader, that there have been a number of arrests and unsuccessful resuscitations in previous months. That with respect to a given child there is some concern about the status of the child during the shift, that the team leader draws up drugs which are used in the arrest, namely bicarbonite, calcium and adrenalin --

THE COMMISSIONER: Wait a minute, I anticipate all of the problems. Is this the one about the predrawing of --

MS. KITELY: Yes, sir.

THE COMMISSIONER: Is it unusual, I suppose it is, is it unusal or improper for a nurse with a very sick child who might conceivably suffer a cardiac arrest to draw up the CPR drugs, ahead of time; is that what you have in mind.

MS. KITELY: You do like to change my scenarios.

THE COMMISSIONER: Well, isn't that what you wanted?

MS. KITELY: Yes, sir. What I am trying to do is round out some sort of hypothetical

facts.

THE COMMISSIONER: All right. Okay.

MR. ROLAND: I am happy with your question, sir.

MS. KITELY: That was going to be the question surprisingly enough, it was exactly the question.

THE COMMISSIONER: You are not unhappy with it?

MR. LAMEK: I am delighted with yours sir.

MS. KITELY: I haven't even got to mine yet.

THE COMMISSIONER: All right. Go ahead.

Q. If I can finish the scenario. The team leader draws up these three drugs, normally used in an arrest, labels them and places them on a tray on top of the cardiac monitor in the child's room. The question is,is that good nursing practice?

THE COMMISSIONER: You can answer that.

THE WITNESS: Is it okay to answer now?

THE COMMISSIONER: Yes.

THE WITNESS: Yes.

Q. Can you expand?

A. And the thing is that if they have a type of problems,they are going to be smart and attempt to organize,to anticipate problems, that is just good practice.

Q. Is that a scenario and do pause before you answer this one Dr. McGee?

THE COMMISSIONER: This is the B part is it?

MS. KITELY: This is the B part.

Q. Is that scenario open to the interpretation that the team leader knew something about her condition that others didn't?

THE COMMISSIONER: No, you can't have that, that's for me.

MS. KITELY: Well, in my submission, Mr. Commissioner --

THE COMMISSIONER: If she says no,does that mean that I can't interpret it that way? Is that what you are saying, I can't ? You see I am, believe it or not, at some point going to have to sit down and decide what happened here, and I'm going to do it regardless, with the greatest of respect to Dr. McGee, and she is a vastly better nurse than I am. She is probably better than I am drawing inferences

from peoples evidence but she is not recognized as that. So I am the one that has got the job and I am going to do it.

MS. KITELY: I quite agree that it is your job, sir. The whole point of having Dr. McGee assist you is by putting these scenarios in the environment that she has been in for for 31 years.

THE COMMISSIONER: That means I have to go through everybody else in the room and ask them what they think about it too, because they have as much right to determine those questions as Dr. McGee has.

MS. KITELY: I guess the difference between us is credibility.

THE COMMISSIONER: Yes. All right. At any rate I am ruling out the B part of 4. Can you go on then to number 5, do we have a fifth scenario yet or do we have a C?

MS. KITELY: No just A and B on that one, sir. I am looking for the offensive parts before I say it.

THE COMMISSIONER: Yes. All right.

Q. Dr. McGee, would you assume that we have a team leader and that we have a staff nurse who has care of child X for two consecutive

nights. In this Hospital code 23 means a doctor is required to stat and a code 25 means that the arrest team is summoned. During the course of the shift the staff nurse assesses the patient and asked the team leader to call a code 23. The team leader assesses the patient and decides to call a code 25. The team leader and staff nurse have a brief disagreement, before either code is called the child arrests. This is the third arrest in approximately three weeks. I ask you to comment on the difference in nursing judgment between the staff nurse on the one hand and the team leader on the other.

MR. BROWN: I am put in the awkward position sir. As much as I like a favourable answers. First of all I am not sure that the facts are correct and that a code was not called before the child went into arrest.

THE COMMISSIONER: I think there was some suggest -

MR. BROWN: I think there was some suggestion that the nurse might have been on the way to put in the 23 as the child was arresting and then indeed it was turned to a 25, but that is a matter of argument. Secondly, if Dr. McGee is being asked to say who was right and who was wrong,

I submit that is not a proper question to be put to her not withstanding her expertise in nursing, that is your job.

If Dr. McGee is being asked to comment on the frequency and differences of judgement between nurses in assessing the care of a child, and the nature of differences that might arise in critical situations, that might be within her realm of competence. I submit the question as framed as to really who was right and who was wrong and is not properly.

THE COMMISSIONER: Am I not correct that all you are really trying to establish that the sort of differences of opinion are ligitimate and people can have them.

MS. KITELY: I was not going to ask, as my friend has queried whether something is right or wrong. I want a comment on the judgement --

THE COMMISSIONER: What comment do you want --

MS. KITELY: I will get Dr. McGee's answer.

THE COMMISSIONER: All right. Dr. McGee won't be lead, you go ahead and say what you want to say. What is it you want, do you want to find

whether this is a legitimate debate that might go on.

MS. KITELY: I wouldn't use the word legitimate or some of my friends will be on their feet.

THE COMMISSIONER: Is this not the sort of thing, is that the question that you want,does this the sort of thing that happened.

MS. KITELY: Mr. Commissioner, I was trying to put the question in a non-leading fashion.

THE COMMISSIONER: Well, try it again.

MS. KITELY: More simply, could you comment on the differences between the nurses in that scenario?

MR. YOUNG: Mr. Commissioner, do we not have to know something about the baby. I mean if she is going to comment upon whether or not it is appropriate or not, then surely we must -- I mean, there must be instances where to have that sort of discussion would be totally, would not work to the baby's benefit, would not assist the baby. There are other discussions where I am sure that would be a very appropriate action for nurses to take, or an understandable action. But without knowing the history of this child and what was going on with that

child at that time, I don't see this answer is of any use.

THE COMMISSIONER: Why can't we let Dr. McGee comment, that is really all she was asked to do was comment on that situation and see what she says.

MR. YOUNG: Comments on what, sir.

THE COMMISSIONER: On the situation that the two nurses at the scene, and the baby's possible arrest and simply not disputing the question of a code 23 or code 25.

MR. YOUNG: I still think you might want to know something about the child.

THE COMMISSIONER: I would.

MR. YOUNG: I just don't see that the hypothetical would do us any good.

THE COMMISSIONER: No. Well, all right. I am going to allow that question. If you would, if you can remember the question, the question was posed a long time ago, can you tell us?

THE WITNESS: If I have interpreted the question correctly you are asking me if whether or not I anticipated a difference in judgement versus whether or not a code 23 is appropriate versus the code 25 appropriate, they were two different kinds of questions.

Q. The 23 and 25, Dr. McGee is an example of a nurses judgement. I am asking you to comment on differences in the nurses judgement in that context?

A. Okay. Anywhere where there is a judgement call there is going to be a difference in judgement. So the fact that two people disagreed on a judgement is even to be expected.

Q. Although what is significance is it that the team leader overruled the request for a code 23?

A. That is not unusual at all, team leaders frequently do that. She is a low risk taker, she is going to - she was not going to chance it, she was going to have somebody there. I don't know what else I can add given what I have got.

MS. KITELY: Can I have one moment, sir?

THE COMMISSIONER: Yes, certainly.

MS. KITELY: I have left the scenario, sir, you will be pleased to hear.

THE COMMISSIONER: I won't complain.

MS. KITELY: Q. And I have this question, Dr. McGee: Mr. Lamek said last week in volume 144 at page 3256, and I quote:

> " I have heard suggestions for months now that your report is going to change the face of nursing and nursing practices throughout this province. "

Can you help us with your opinion as to the effect of this inquiry on nursing and nursing practices?

MR. LAMEK: I am not sure I need to say very much about that, Mr. Commissioner. With the greatest of respect to Dr. McGee, her opinion as to what will be in the report and the effect it may have on nursing and nursing practices is not really a matter that you need to concern yourself with, sir.

MS. KITELY: If I might reply, sir.

MR. YOUNG: I would hope that the perceived or possible reaction of various individuals in the community would not influence you in making up your report. For that reason I don't think it is an appropriate question.

THE COMMISSIONER: Well, it is a statement from the heart. I don't promise to pay any attention to it, but I will allow the question.

MS. KITELY: Thank you, sir.

Q. Dr. McGee, would you like me to put the question?

A. Would you do it again, please.

Q. Mr. Lamek referred in volume 144 as to the scuttlebutt as it were that this inquiry might change the basic nursing and nursing practices in Ontario. My question to you: Can you help us, from your perspective, as to the effect on nursing and nursing practices in Ontario of this Commission?

A. I would anticipate that it would have both negative and positive effect. I believe that the health care system and nursing service and nursing science, within that system, will be improved by the forced self-examination of

both the system and the discipline, so in that respect I would expect positive changes, a positive effect at least. I don't know if there will be much change but there will be some kind of effect on that self-examination. There will be some negative sides in that there will be, and I don't know, I am speaking off the top of my head a little bit here, but I would expect an increased militancy on the part of nurses in their protection of themselves.

Q. Can you tell me why?

A. I am under the impression, from what you said, that several times this morning I have heard hours and hours of discussion about certain practices and days and days on certain kinds of things. That means there has been more attention paid to details than I had realized. I wasn't aware of this so extensively.

The other example the Commissioner raised this morning is the dilemma of a decision and a no-win situation of some nurses in certain situations. In that event, they are going to have to become more self-interested than they have been in the past. They are going to have to address,

not only our tremendous area of responsibility that apparently exists, but the necessity to have control over it and over our decisions, in fact. We are going to have to address with more care what seems to be manifested as system failure. In that event it consists of both the negatives and the positives.

MS. KITELY: Thank you, very much, Dr. McGee. Those are my questions, Mr. Chairman.

THE COMMISSIONER: Yes, all right, thank you. Mr. Lamek, do you want to go now?

MR. LAMEK: Whatever you wish. Could we break for lunch at this stage and start after lunch?

THE COMMISSIONER: I wonder if we could take a poll. We want Dr. McGee, if possible, to be finished today. Mr. Brown, have you any questions?

MR. BROWN: I have no questions.

MS. RAE: I don't anticipate any.

MS. CECCHETTO: Five to ten minutes.

MR. YOUNG: I have no questions.

THE COMMISSIONER: Mr. Roland?

MR. ROLAND: I don't think I have any questions, but I want to think about it.

THE COMMISSIONER: All right. I

was going to ask Miss McIntyre and Miss Symes. She is on the same side.

MS. SYMES: No questions.

THE COMMISSIONER: Mr. Labow?

MR. LABOW: No questions.

THE COMMISSIONER: Mr. Olah, are you still playing this game?

MR. OLAH: May I say this, sir, that the only reason I came over was to tell you, sir, that A) I will be calling no evidence and B) I don't want to have a function to play in Phase II. Once I put that on the record I will leave. I will be back for submissions.

THE COMMISSIONER: All right, that's fine. We enjoyed having you. There is no reason and particularly this room is rather cramped quarters so any time anybody leaves we applaud.

MR. OLAH: That may be the only basis on which I will get an applause.

THE COMMISSIONER: 2:15.

---(Luncheon Adjournment)

RD/ac
AA-1

---(Upon Resuming)

THE COMMISSIONER: Mr. Lamek?

MR. LAMEK: Thank you, sir.

EXAMINATION BY MR. LAMEK:

Q. Dr. McGee, I will not be very long and you will be relieved to know that I am not going to ask you a single hypothetical question.

Do I understand you correctly, from your C.V., Doctor, that you have just done the one piece of research on drug errors.

A. On error as such. I did another one on poison ingestion in pre-schools, which is one form, I suppose, isn't it?

Q. Perhaps an associated topic.

A. Right.

Q. As I understand you this morning, you identified certain factors that were conducive, as I understood you, to making of errors, sort of situational factors that it be more likely that errors might occur.

A. Yes.

Q. I think you identified a number of them: emergency situations; competitive

demands for the attention of the nurse and so on; pressure in a given situation. Do I have them all?

A. That wasn't quite a complete list of all of the potential room for error.

Q. The ones you identified?

A. You mean in the administration or the ultimate result.

Q. I was really talking about administration I think.

A. Okay. The transcription errors, the preparation errors, the patient identification errors.

Q. You identified certain situations --

A. Order errors.

Q. You identified certain situational conditions which, as I understood you, made it more likely that errors would occur.

A. Yes.

Q. Competitive demands for the nurses' time and attention, for one, and the pressure of any given situation, whether it was

an emergency --

A. Any anxiety associated.

Q. Yes, that's right. Can I fairly take it that the absence of those factors may reduce the likelihood of error?

A. One would hope that if all other things being equal that if there isn't competition and if there isn't other associated stresses that one would hope that, one would expect that the probability is reduced.

Q. With respect to the Lombardo situations --

A. Whichever that is.

Q. That was the one in which Miss Kitely reminded you or told you that Miss Cronk, in the course of cross-examination, had identified and obtained the agreement of the witness to eight errors?

A. Oh, yes.

Q. You looked at the situation and said, well, by your count that may be as few as four.

A. Yes.

Q. I take it that on your

understanding of that situation that four was the minimum number of errors that appear to have occurred?

A. Well, in that situation.

Q. In a hypothetical situation?

A. In that situation.

Q. Of digoxin being given for heparin?

A. Given the minimum number of potential.

Q. Yes, would be four as I understood your evidence.

A. Okay. There is an instance where it could be reduced to two.

Q. Would you help me with that?

A. If the right box is selected, because in the count I think that was one error point.

Q. Yes.

A. It is possible. If the right box is selected and the right drug is selected, you are reducing, eh?

Q. Yes, I understand.

A. So you could conceivably then only have an error in, say, dosage.

Q. It would be difficult to understand, would it not, how drug A could be given for drug B if the right box of ampule was selected.

A. Right, so that would be the point in error.

Q. In the situation which I think you were being asked to consider, that is to say the possibility with respect to Baby Lombardo, digoxin had been administered instead of heparin.

A. Okay.

Q. That, of necessity, involves, does it not, the selection of the wrong box, wrong ampule and then proceeding with the administration?

A. Right.

Q. And then, at least one error by the checking nurse in not fulfilling her particular function, whatever it was?

A. Yes.

Q. Indeed, I take it, Dr. McGee, and I mean no disrespect, that you are not

familiar with the particular procedures in effect at the Hospital for Sick Children at the time with respect to the duties of the checking nurse?

A. That is correct.

Q. And, indeed, if the nurse had the obligation to make sure the right box and the right ampule was selected and so on then perhaps eight would not be an outlandish number to suggest, that the total errors involved in the situation?

A. If, in fact, the procedure was established in that order, that is reasonable.

Q. It could be as many as eight, but it could be as few as four.

A. That is the point.

Q. Depending on the role of the checking nurse?

A. Right.

Q. But, in any event, you said, and I think I made a note of the word you used, even assuming a minimum of four errors to produce the result of digoxin being administered for heparin, you are still talking about compounded errors you said. That is to say that there have to

be those four flaws occurring in sequence or simultaneously to produce that result. Would I be right in thinking that the number of constituents that you have to have in a chain to produce a result, the higher the number of constituents you would have to have in a chain to produce the result is less likely the result will be produced?

A. The higher the number of constituents required --

Q. To produce a result.

A. Required to produce a desired result.

Q. Or an undesired result, for that matter, the less likely it is.

A. That all things will happen as desired.

Q. The less likely the result will not occur. Understand me?

A. Whether it did not occur or did occur the increased number of variables increase the likelihood of risk of shift from the desired process.

Q. All right. Now, let's put that in terms, and I hope I can understand it. If

the object of the exercise is to avoid giving digoxin for heparin then the greater the number of steps that have to be taken to produce the bad result to make the ultimate mistake, the more likely it is that at one of those points the error won't be made and the chain will be broken. Is that fair?

A. The error won't be made. The chain not getting broken is critical, admittedly. It gets broken it is critical to the prevention of the error.

Q. Let's start with the very first error. If the nurse does not take the wrong box down from the shelf then we are off to a flying start in avoiding the confusion of drugs, are we not?

A. Square one has been established.

Q. If having taken the wrong box she takes the ampules out and checks the ampules and finds, whoops, this is not heparin, it is digoxin, we have broken the chain leading to the error.

A. To this point assuming there are no additional errors.

Q. In terms of the dosage she may or may not give too much, but that is an error perhaps of a different kind, is it not?

A. Well, it was I believe included in the list, a potential for error.

Q. If the checker says, whoops, that is not a heparin ampule, that is a digoxin ampule, once again the result is achieved. She is making that wrong substitution.

A. Further error is diminished.

Q. In other words, what I am suggesting to you, therefore, is that in that four step process there are at least three points where the error can be detected before the ultimate error occurs?

A. Yes.

Q. All right. If, indeed, there are eight steps to be taken then that increases the chances, does it not, that at one point along that chain someone is going to say, hey, you have got the wrong drug?

A. If at each of these points, there is also a checker.

Q. Or the person herself --

A. Checks.

Q. She has continuing opportunities to correct such errors she has made in the past.

A. Up until, assuming you have the right drug.

Q. I understand.

A. Okay.

Q. I can understand that if there is an emergency situation, a critical situation, enormous competitive demands for the time of the nurse, who is trying to locate and administer heparin that there is a greater enhanced risk that she will make a mistake, perhaps make four mistakes, six mistakes, and produce the unfortunate result.

Were you aware when you were considering that situation that the evidence of Nurse Bucci had been that on the night when she administered the heparin or she believed to be the heparin to the Lombardo child it was an unusually slow night and the workload was not particularly heavy and she was not under any particular stress. Would that be a factor which in combination with the compounded errors, which would have had to occur, would, in your

experience and in your opinion, make it less likely that drug substitution would have happened?

A. In sheer probabilities it is less likely.

Q. We can't say more than that.

Miss Kitely also referred you to the range of drug error rates which had been referred to by different pharmacologists and so on in this Commission, and, in particular, refer you to those mentioned by Dr. MacLeod from the Hospital and told you that on his calculation, given an assumed number of doses of drugs on the cardiology floor, there could be as many as four drug errors a day on the cardiology wards. Do you remember having those numbers put to you?

A. Yes.

Q. And Miss Kitely quite rightly said over a nine month period that would amount to about a thousand drug errors, assuming those average rates.

A. All other things being equal.

Q. Yes, assuming those average

rates.

Is it reasonable to believe, in your opinion, again based upon your experience and research, that the vast majority of those errors would be errors which produced no significant ill effects upon the patients?

A. I can't answer that. I don't know.

Q. I take it there would be in your experience no reason to believe that drug errors would be more rife in any one nine month or twelve month period on a floor than in any other nine or twelve month period, unless there had been major changes in the operation of the floor.

A. Chance runs of behaviours are hard to generalize. Patterned events are rather difficult to generalize about.

Q. I understand, and I am not suggesting for a moment that errors over a nine month period, if you could be aware of them all, would run within a very narrow band of a thousand, give or take 50. I am not suggesting anything of that sort.

A. Or randomly selected block

of time.

Q. You wouldn't expect to see over an extended period of time, like a nine month period, gross differences?

A. I would expect variance. I would expect fluctuations.

Q. Yes. Would you expect gross variation from one period to the other?

A. It is conceivable it could be.

Q. No doubt there would be, as you say, fluctuations, certainly day-to-day, week-to-week, month-to-month, maybe even year-to-year, but in the absence of drastic changes, either in the drug delivery system used on the floor or in the size and characteristics of the ward population, you would expect, would you not, over the longhaul, taking a number of comparable periods, one after the other to see a more or less consistent pattern with the variations and fluctuations?

A. And the assumption that there are no new drugs.

Q. Yes.

A. And that there is the same

Drug House manufacturing and delivering and distributing.

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Q. Yes?

A. The same pharmacutical procedures obtain, that the same patient profile obtains, that there is no difference in patient profile therefore no difference in ordering; no difference in requirements associated with technology. Those are a lot of no differences.

Q. Yes.

A. In the health care system in the past 5 years.

Q. Okay. Are you telling me, therefore, if you were to see a very substantial variation between comparables. You would look to see if any of those matters had changed?

A. That's correct. You would need to examine the total, the components of the total system and their interaction.

Q. It would also be relevent do you think to look at the consequences of what you consider to be drug errors?

A. In terms of?

Q. In terms of the effect upon patients; whether there were fatalities associated with drug errors and if so in what numbers?

A. Yes, I would agree that that

BB2

would be part of your analysis.

Q. And if indeed there appeared to be an unusually large number of fatalities that were perhaps explainable on the basis of increase in drug errors of a particular kind, in seriousness and gravity and so on, you would also I take it be interested in looking for other explanations of that increase in mortality?

A. I would think.

Q. Of course you would.

I don't think I have anything more, thank you very much, Doctor.

THE COMMISSIONER: Mr.Brown?

MR. BROWN: No questions, sir.

THE COMMISSIONER: Miss Rae?

MS. RAE: No questions.

THE COMMISSIONER: Miss Cecchetto?

MS. CECCHETTO: Thank you, sir.

CROSS-EXAMINATION BY MS. CECCHETTO

Q. My name is Lucy Cecchetto. I appear on behalf of the Crown, the Attorney General and the Coroner's office.

This morning Ms. Kitely referred you to Dr. Spielberg's evidence and Dr. MacLeod's evidence. I would like to refer you to Dr. Kauffman's evidence,

BB3

Volume 83, page 101.

THE COMMISSIONER: I'm sorry?

MS. CECCHETTO: 8101, and the question is as follows; I'm afraid there is not an extra Volume in the room.

"Q. Now, Doctor, we have heard a lot about medication error and the frequency of medication errors in hospitals, and you were examined this morning by Ms. Symes on medication errors. Can I ask you to comment how often medication errors in hospitals resulted in death; is that as common as medication error?"

And his answer is -

THE WITNESS: Could you read that last sentence again?

"Q. Can I ask you to comment how often medication errors in hospitals resulted in deaths; is that as common as medication error?"

And the answer is:

"A. No, it is not as common as medication error, fortunately. I cannot give you specific numbers or percentages but I can tell you that the great

BB4

majority of errors that are detected are of little or no significance to the patient in terms of causing ill effects to the patient, certainly not death. Death must occur with very very small percentage of the medication errors that are made, I would guess under 1 percent. But I do not know the exact numbers."

Would you agree with that statement?

A. Not automatically. And the reason why not automatically I am not sure on what constituted his base in terms of saying that medication errors are for the most part - not serious you read?

THE COMMISSIONER: Not significant.

THE WITNESS: Not significant. I don't know that.

MS. CECCHETTO: Q. Well, would you agree with him that whatever the frequency of medication errors that occur, that frequency does not amount to-- does not in each and every case amount to death; would you agree with that?

A. I would assume that that is a reasonable conclusion.

Q. Would you not agree with him that

by and large, although medication errors occur, what I took from that passage and you can see if you agree with me on this, that although they occur by and large they do not result in death? They don't result in that serious consequence?

A. You are asking me what all contributes to people dying?

THE COMMISSIONER: No, I think all she is asking - I think it is self-evident although every time I think anything is self-evident I find I am wrong. I think it is self-evident that most medication errors that take place in hospitals do not result in the death of a patient.

A. If the data that were presented a few moments ago are accurate, if there are in fact that many errors, then obviously -

THE COMMISSIONER: It would be a very dangerous place to go.

THE WITNESS: Well, obviously they are not - no, they don't result in death, but I guess I misunderstood the question. I thought you might be suggesting that what all are people dying from it could be also aided by medication error.

MS. CECCHETTO: Q. I am not disputing that, Doctor, but what I am asking you is if you had a great

B6

increase in death it may be that some of that increase is due to medication error, but I am also trying to get your opinion on whether or not however frequent medication errors are, by andlarge they don't result in death very often? Would you agree with that?

A. Not as you have said it. I will have to say I don't know to that. I would agree with you that probably they have less impact on deaths than other things.

Q. Now the only other question I would like to ask is with respect to the Coroner and I am not going to ask you a hypothetical but what I am going to ask you is I note from your curriculum vitae you have been involved for a great deal of your nursing career in teaching in that aspect of nursing.

Are nurses in nursing school taught about the Coroner's Act and about the obligations to report to the Coroner?

A. The obligation to report is what is underlined.

Q. All right. Are they taught that they -

THE COMMISSIONER: Obligated to report to the Coroner; is that it?

THE WITNESS : Obligated to document.

BB7

THE COMMISSIONER: Well I think the question that Miss Cecchetto was asking are they taught in nursing school whether the provisions of the Coroner's Act - it is recommended to them when something is unusual that they should report it to the Coroner?

THE WITNESS: The extent to which they are citizens they are expected to report.

MS. CECCHETTO: Q. Perhaps I would put it to you this way; if the witness could get Exhibit 117 which is a chart it might assist her to follow with me. At page 26 the Coroner's Act is set out. That is the chart of Laura Woodcock.

THE COMMISSIONER: What page?

MS. CECCHETTO: Page 26.

THE WITNESS: Now would you tell me the page?

MS. CECCHETTO: Page 26.

THE WITNESS: Thank you.

MS. CECCHETTO: If you would look at Section 9 there is reads:

"Every person who has reason to believe that a deceased person died",

and if you skip down to (d),

"suddenly and unexpectedly":

BB8

"shall immediately notify a Coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he shall in turn immediately notify the Coroner of such facts and circumstances."

Are nurses taught about this Section in the nursing school?

A. It is not emphasized as a nursing function any more than it is emphasized for any citizen. What they are taught is that all people living in an area, whether they are in practice or not, have this obligation to report.

Q. Well, is it ever discussed that they, either in nursing school or in the practice of nursing, that if there is a concern about a death that they should report that to the Coroner?

A. As individuals it is not emphasized.

Q. In your experience over some 30 years of nursing has it ever come to your attention that nurses have reported cases to the Coroner.

A. I have had one experience that I can recall where there was an offer of some data to a Coroner, but it didn't go very far.

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Q. And the concern I have this morning is when the Commissioner in response to the hypothetical of Miss Kitely put forward that a nurse could not be expected possibly to report a case to the coroner, has there ever been a consideration that if a nurse is concerned - or you have never been involved in discussions where a nurse is concerned and is concerned that perhaps - I am not suggesting that this is necessarily the situation that pertains here but is concerned that perhaps the Hospital has not reported a case that she should take the initiative and report to the coroner?

A. Needless to say most nurses, there are exceptions, there are a few mavericks, but in most cases she does rely on her immediate superiors to pass on the information that she documents.

Q. I recognize that, but the concern I have, Doctor, is looking at that section, "every person", so although a nurse may be as every other citizen may be compelled to report that, she stands perhaps in a better position than some other citizen because she is involved in a hospital situation.

A. Where she has better opportunity you are suggesting?

Q. Yes.

A. It has not been a practice. For example, the one instance it says "died suddenly and unexpectedly". Nurses have frequent experience with patients dying unexpectedly. It is not an uncommon phenomenon.

Q. I recognize that, but still I am asking you - I am concerned that if there is a concern on the part of the nurse that the child has died suddenly and unexpectedly, as good nursing practice is there not a concern that that case should be reported to the coroner by the nurse if the Hospital has not?

A. I submit not, and the reason being the frequency of very ill people dying unexpectedly is not unusual. That happens fairly frequently. She doesn't go to the coroner every time that happens.

Q. I'm not suggesting that she should go to the coroner every time that happens. I am asking you for your opinion on good nursing practice, where there is a concern about a death, and

I recognize that nurses come into contact with death more often so I do recognize what you are saying. But if there is a concern -

A. If the nurse was in private practice that would be an expected behaviour. If she is not in private practice, if she works for an organization, there is a system established to funnel information through to the appropriate person.

Q. Although there is a system is it not the responsibility also of the individual nurse, though?

A. She has the same kind of responsibility as the citizenry have for that.

Q. All right. Well then taking it as her responsibility as a citizen, is she not compelled then to report it if she is satisfied someone above her is not reporting it and she has a concern that is enunciated in the Coroner's Act?

A. Some of them do. Most don't.

Q. Now picking up on Miss Kitely's last question to you with respect to the effect of this Commission, do you think that perhaps

in the future this aspect of reporting to the coroner might be reviewed?

A. It may well.

MS. CECCHETTO: Thank you.

THE COMMISSIONER: Before we proceed I would just like to make my contribution for the law of this Province. You see on the same page, The Human Tissue Gift Act, section 7, sub-section 4,

" Nothing in this section in any way effects a physician in the removal of eyes for cornea transplants. "

That's the wrong spelling of "affects". Do you want to pass that on too?

MS. CECCHETTO: The Human Tissues Act?

THE COMMISSIONER: All right. Mr. Young?

MR. YOUNG: No questions, thank you.

THE COMMISSIONER: Mr. Roland?

MR. ROLAND: No questions.

THE COMMISSIONER: Mr. Labow?

MR. LABOW: No questions.

THE COMMISSIONER: Mr. Shanahan?

MR. SHANAHAN: No questions.

THE COMMISSIONER: I guess we come back to you, Mr. Lamek.

MR. LAMEK: I just have a confession, sir, before you blame Ms. Cecchetto. I was on the committee that drafted The Human Tissue Gift Act.

No further questions.

THE COMMISSIONER: Miss Kitely?

MS. KITELY: No questions.

THE COMMISSIONER: All right, thank you, Dr. McGee. Thank you indeed. You have been very helpful.

MS. KITELY: Thank you, sir.

---(Witness Withdraws)

THE COMMISSIONER: Now are there any further witnesses that anyone proposes to call in Phase I?

MR. LABOW: Subject to my discussion with Commission Counsel.

THE COMMISSIONER: Well, I think I know what the problem is. It is about Mrs. Gosselin,

isn't that right?

MR. LABOW: Yes, I have given Commission Counsel the affidavit that came in today.

THE COMMISSONER: Well, we'll try and sort that out, and of course there is no reason why you can't even interupt argument if necessary.

DM/hr

THE COMMISSIONER: Well, that is all of the evidence I take it, is it? Miss Cronk, you have a letter?

MS. CRONK: Yes, sir. As some counsel are aware we have had discussions with counsel for the Hospital concerning the merits of the reattendance of Dr. Stephen Soldin . You will recall when he last appeared before you, sir, he gave evidence regarding certain ongoing research that he was involved with which had to do with an investigation of possible endogenous materials that might cross react with digoxin on RIA digoxin technics.

Mr. Roland has been kind enough at our request to provide us with a letter outlining the status of that research. Simply for your benefit, sir, and for those other present in the room I would like to read that letter into the record then ask you if it might be marked. The letter is addressed to myself:

> "You will recall that Dr. Soldin testified before the Commission about certain ongoing experiments being conducted at the Hospital. This ongoing research involved an investigation of possible endogenous materials that

cross react with digoxin on RIA digoxin essays. These experiments have continued to the present time. Dr. Soldin informs us that the research has not yet reached a stage that it would be appropriate for him to testify before the Commission about this work. In our view until the research has been completed and the results have been properly and independently assessed it would not be helpful or appropriate to entertain any additional evidence from Dr. Soldin. We will inform you of the results of Dr. Soldin's experiments and his research once they have been completed and have been independently reviewed by an expert panel".

I would ask that this be filed as an exhibit.

THE COMMISSIONER: Who wrote that letter?

MS. CRONK: This is under the signature of Mr. Roland of Messrs. Gowling and Henderson. I am greatful to my friend for having provided.

THE COMMISSIONER: That is a 418.

---EXHIBIT NO: 418: A letter from Mr. Roland to Ms. Cronk re Dr. S. Soldin.

THE COMMISSIONER: Well then that being the case we won't sit tomorrow but on Thursday at 10:00 o'clock, I have a statement to make on the future of Phase II. After I have done that we will continue the argument on the form of argument for Phase I,and we may or may not consider the problem of standing in the Phase II. There has been some suggestion that it is a little premature. The reason that I was concerned about it was that I wanted to have it settled before we proceeded to Phase II but we may be able to get around that somehow . But that as I see it is what the future is. Then on the 4th of June we will start the argument. On anybody's submission with respect to argument in Phase I,please be prepared to make it on Thursday morning after I have made this statement. Yes, Ms. Kitely?

MS. KITELY: Mr. Commissioner you may or may not consider the standing issue on Thursday?

THE COMMISSIONER: Yes.

MS. KITELY: On what will that depend?

THE COMMISSIONER: I am not exactly - it will depend on, I don't know, my mood. The problem

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is this If I refuse to grant standing to someone I want whoever it is that does not get the standing to get it out of his litigous system or her litigous system before we start in on Phase II. However, I can probably resolve the whole problem, because I have looked at the Act,and the Act says that if a case is stated that I can't proceed with that particular matter. So obviously if a case is stated as to the standing and so on, the simple answer is to let him have standing pending the decision of the Court. So it wouldn't hold us up. I think that is - it would hold us up in the sense that we have too many people, but having standing we will be slowed down in the proceedings, but I think we can get over that. The argument against having it is that we don't know the form that Phase II is going to take and it makes it difficult for people to argue, or even to decide when we don't know.

MS. KITELY: So should we then be prepared to argue the standing in the event that you choose to go ahead with that? I just want to make sure that we are in a position to argue it.

THE COMMISSIONER: Can I just have -- do you think it is premature? I am asking you when you are here now, or would you like to know? I can ask you to

presume,and you are in a most favourable position,for you to have standing and argue accordingly. Do you think it should be done on Thursday or do you think it should wait until we know what Phase II is going to consist of?

MS. KITELY: My off the cuff answer, sir, is that it is premature that we need some definition before we can deal with it.

THE COMMISSIONER: Is that general opinion, does anybody want to --

MR. LABOW: I would take that same position. I think it is premature.

THE COMMISSIONER: I think it could have been done, but if that is the general opinion we won't argue the question of standing in Phase II. Although any others who are prepared to say they don't want standing under any circumstances I can't tell you how popular they will make themselves with me when they do it. I think we already have that from Mr. Knazan and Mr. Olah.

MR.YOUNG: I was toying with the idea, I am anxious to get back in your good graces again, it is a small cost to pay.

THE COMMISSIONER: That being the case we will probably have not more than half a day on Thursday

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and we will then proceed to argument on the 4th. Is anybody complaining, I don't think it will do you much good,about the length of time given to argument, do all of you think it is too much.

MS. KITELY: All of it.

THE COMMISSIONER: Then until Thursday at 10:00 o'clock.

--- Whereupon the Hearing was adjourned at 2:50 p.m. until 10:00 a.m., Thursday the 17th day of May,1984.